NOTICES OF PROPOSED RULEMAKING

Unless exempted by A.R.S. § 41-1005, each agency shall begin the rulemaking process by 1st submitting to the Secretary of State's Office a Notice of Rulemaking Docket Opening followed by a Notice of Proposed Rulemaking that contains the preamble and the full text of the rules. The Secretary of State's Office publishes each Notice in the next available issue of the *Register* according to the schedule of deadlines for *Register* publication.

Under the Administrative Procedure Act (A.R.S. § 41-1001 et seq.), an agency must allow at least 30 days to elapse after the publication of the Notice of Proposed Rulemaking in the Register before beginning any proceedings for adoption, amendment, or repeal of any rule. A.R.S. §§ 41-1013 and 41-1022.

NOTICE OF PROPOSED RULEMAKING

TITLE 6. ECONOMIC SECURITY

CHAPTER 3. DEPARTMENT OF ECONOMIC SECURITY
INCOME MAINTENANCE

PREAMBLE

1. Sections Affected — Rulemaking Action

Article 25	Repeal
R6-3-2501	Repeal
R6-3-2502	Repeal
R6-3-2503	Repeal
R6-3-2504	Repeal
R6-3-2505	Repeal
R6-3-2506.	Repeal
R6-3-2507	Repeal

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

   Authorizing statutes: A.R.S. §§ 41-1954(A)(3) and 46-134(12)

   Implementing statutes: A.R.S. §§ 41-1954(A)(3) and 46-134(12)

3. The name and address of agency personnel with whom persons may communicate regarding the rule:

   Name: Vista Thompson Brown

   Address: Department of Economic Security
   1789 West Jefferson, Site Code 837A
   Phoenix, Arizona 85007

   or

   PO Box 6123, Site Code 837A
   Phoenix, Arizona 85005

   Telephone: (602) 542-6555

   Fax: (602) 542-6000

4. An explanation of the rule, including the agency's reason for initiating the rule:

   The Department plans to repeal the rules listed above. These rules were adopted in March 1984 to govern a temporary demonstration project. Authority to operate the project ended after several years. The Department has not operated the project or used the rules since the late 1980's. The rules are unnecessary and should be repealed.

5. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

   Not applicable

6. The preliminary summary of the economic, small business, and consumer impact:

   The repeal of these rules will have no measurable economic impact on any group. The repeal has intangible benefits by eliminating the confusion that results from having outdated, unenforced rules as a part of the *Arizona Administrative Code*.

7. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement is:

Name: Vista Thompson Brown

Address: Department of Economic Security
1789 West Jefferson, Site Code 837A
Phoenix, Arizona 85007

or

PO Box 6123, Site Code 837A
Phoenix, Arizona 85005

Telephone: (602) 542-6555

Fax: (602) 542-6000

8. The time, place, and nature of the proceedings for the adoption, amendment, or repeal of the rule or, if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

The Department has not scheduled oral proceedings on this rule repeal action. The Department will schedule oral proceedings if 5 or more people request them by sending a written request to the person named in paragraph 3 above, before 5 p.m. on Friday, April 4, 1997, the date scheduled for the close of record. The Department will accept written comments from the present date until the close of record date. Written comments should be mailed to the person identified in paragraph 3 so that the Department receives them before the close of record date. To request accommodation to participate in the public comment process, or to obtain this notice in large print, Braille, or on audio tape, contact Vista Thompson Brown at (602) 542-6555, PO Box 6123, Site 837A, Phoenix, Arizona 85005. TDD 1-800-367-8939.

9. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable.

10. Incorporations by reference and their location in the rules:

Not applicable.

11. The full text of the rules follows:

TITLE 6. ECONOMIC SECURITY

CHAPTER 3. DEPARTMENT OF ECONOMIC SECURITY
INCOME MAINTENANCE

ARTICLE 25. CASE RECORD

~~R6-3-2501. Authority~~
~~R6-3-2502. Definitions~~
~~R6-3-2503. Eligibility Criteria~~
~~R6-3-2504. Incentive Payment~~
~~R6-3-2505. Adequate notice to recipients~~
~~R6-3-2506. Child support collection~~
~~R6-3-2507. Retroactive payments~~

ARTICLE 25. GRANT DIVERSION

~~**R6-3-2501. Authority**~~

~~The Arizona Department of Economic Security (DES) is the state agency responsible for the administration of a demonstration and research grant diversion project (Project), pursuant to Section 1115 of the Social Security Act, P.L. 98-21, and 42 U.S.C. 602 and A.R.S § 41-1954.~~

~~**R6-3-2502. Definitions**~~

~~The following definitions shall apply in this Article unless the context requires otherwise.~~

~~1. "AFDC" means "Aid to Families with Dependent Children".~~
~~2. "Base Grant" means the total AFDC grant, including the amount of any previous deduction, the individual received in the month prior to entering the project. This amount shall be directed to the wage pool and shall remain unaltered during the project.~~
~~3. "Employment" means a permanent full-time job of 30 hours or more per week which is not temporary in nature and is unrelated to any labor dispute.~~
~~4. "Grant Diversion" means the process that allows a participating public or private sector employer in the state of Arizona to receive an eligible AFDC (A.C.R.R.Title 6, Chapter 4) recipient's base grant, or a portion of the grant for a period of not more than six months as an incentive for providing employment to an eligible AFDC recipient.~~
~~5. "Wage Pool" means a poll of diverted AFDC grants which is used to pay the employer all or a portion of the AFDC grant for not more than six months.~~

~~**R6-3-2503. Eligibility Criteria**~~

~~Eligibility for participation in Grant Diversion shall be limited to individuals who have been recipients of an AFDC grant for three consecutive months or who have completed a job search component of the Work Incentive Demonstration Program (A.C.R.R., Title 6, Chapter 10) or Job Training Partnership Act Program (A.C.R.R, Title 6, Chapter 11) and who meet all of the following criteria:~~

~~1. Have a Social Security number with the last digit 1 through 9;~~
~~2. Have a base grant of $180 or more;~~
~~3. Have no previous experience of the project;~~
~~4. Are not receiving unemployment insurance benefits;~~
~~5. Are applicant payee pursuant to A.C.R.R. Title 6, Chapter 3, Article 4.~~

~~**R6-3-2504. Incentive payment**~~

~~The rate and method of incentive payment from the wage pool to~~

~~participating employers shall be determined by the DES. Before and payment is made, participating employers shall enter into a contract with DES as provided by A.R.S. § 41-1954.~~

~~**R6-3-2505. Adequate notice to recipients**~~
~~Completion and signature of an authorization form by the AFDC recipient to effect the grant at the earliest date following the commencement of employment shall constitute adequate notice pursuant to 45 CFR 205.10.~~

~~**R6-3-2506. Child support collection**~~
~~Child support collection on behalf of AFDC recipients in Grant Diversion shall continue in accordance with A.C.R.R. R6-3-413 while the AFDC recipient is participating in Grant Diversion.~~

~~**R6-3-2507. Retroactive payments**~~
~~Participation in Grant Diversion shall not preclude recipients from receiving retroactive payments to which they are entitled for the period prior to entering the project.~~

NOTICE OF PROPOSED RULEMAKING

TITLE 6. ECONOMIC SECURITY

CHAPTER 13. DEPARTMENT OF ECONOMIC SECURITY
STATE ASSISTANCE PROGRAMS

PREAMBLE

1. Sections Affected | Rulemaking Action

R6-13-701	Amend

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

   Authorizing statutes: A.R.S. §§ 41-1954(A)(3), 46-134(12), and 46-231 through 46-238

   Implementing statutes: A.R.S. §§ 41-1954(A)(3), 46-134(12), and 46-231 through 46-238

3. The name and address of agency personnel with whom persons may communicate regarding the rule:

   Name: Vista Thompson Brown

   Address: Department of Economic Security
   1789 West Jefferson, Site Code 837A
   Phoenix, Arizona 85007

   or

   P.O. Box 6123, Site Code 837A
   Phoenix, Arizona 85005

   Telephone: (602) 542-6555

   Fax: (602) 542-6000

4. An explanation of the rule, including the agency's reason for initiating the rule:

   The General Assistance program provides financial assistance up to 12 months in a 36-month consecutive period to persons who are temporarily disabled and to persons required to care for a disabled person in the home. The Department intends to define disability and update rules on disability requirements to be consistent with statutory eligibility requirements. The Arizona legislative intent is to provide equal treatment of applicants for General Assistance and Supplemental Security Income.

5. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

   Not applicable

6. The preliminary summary of the economic, small business, and consumer impact:

   The rule changes will result in a loss to General Assistance recipients as the changes eliminate the eligibility of a specific population of the recipients. This results in a savings to the taxpayers. Because the Department has not previously tracked eligibility by the sub-category of population eliminated by the rule amendment, the Department cannot tell how many recipients will be rendered ineligible.

   Food banks, soup kitchens, and homeless shelters will be impacted as the General Assistance recipients affected by this rule will have no source of income to meet expenses for basic needs. Ineligible recipients will most likely turn to other charitable institutions to meet those needs.

7. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement is:

Name: Vista Thompson Brown

Address: Department of Economic Security
1789 West Jefferson, Site Code 837A
Phoenix, Arizona 85007

or

P.O. Box 6123, Site Code 837A
Phoenix, Arizona 85005

Telephone: (602) 542-6555

Fax: (602) 542-6000

8. The time, place, and nature of the proceedings for the adoption, amendment, or repeal of the rule or, if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

A person may submit written comments on the proposed rules or economic impact statement by submitting the comments no later than the close of record, which is scheduled for April 11, 1997, at 5 p.m. to the person specified above. Oral proceedings as scheduled as follows:

Phoenix	**District I**
Date:	April 10, 1997
Time:	1:30 p.m.
Location	DES Conference Room 815 North 18th Street Phoenix, Arizona
Coord. Program Mgr:	Carla Van Cleve (846-0001)

Tucson	**District II**
Date:	April 10, 1997
Time:	1:30 p.m.
Location:	DES Conference Room 400 West Congress #420 Tucson, Arizona
Coord. Program Mgr:	Henry Granillo (628-6810)

Flagstaff	**District III**
Date:	April 10, 1997
Time:	1:30 p.m.
Location:	DES Conference Room 220 North LeRoux Flagstaff, Arizona
Coord. Program Mgr:	Pam Estrella (779-2731, ext. 238)

Yuma	**District IV**
Date:	April 10, 1997
Time:	1:30 p.m.
Location:	DES Conference Room, Suite 232 350 West 16th Street Yuma, Arizona
Coord. Program Mgr:	Tim Acuff (782-4343)

Casa Grande	District V
Date:	April 10, 1997
Time:	1:30 p.m.
Location:	DES Conference Room 2510 North Trekell Casa Grande
Coord. Program Mgr:	Dan Van Kuren (723-4151)

Bisbee	District VI
Date:	April 10, 1997
Time:	1:30 p.m.
Location:	DES Conference Room 209 Bisbee Road Bisbee
Coord. Program Mgr:	David Gibbs (428-7702)

Persons with a disability who wish to participate in the oral proceeding may request a reasonable accommodation, such as a sign language interpreter, by contacting the coordinating program manager named above. Requests should be made as early as possible to allow time to arrange the accommodation.

This document is available in alternative format by contacting Vista Thompson Brown at the address and number listed in paragraph 3 above. Requests should be made as early as possible to allow time to arrange the accommodation.

9. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:
Not applicable.

10. Incorporations by reference and their location in the rules:
Not applicable.

13. The full text of the rules follows:

TITLE 6. ECONOMIC SECURITY

CHAPTER 13. DEPARTMENT OF ECONOMIC SECURITY
STATE ASSISTANCE PROGRAMS

ARTICLE 7. GENERAL ASSISTANCE

R6-13-701. State General Assistance Program

ARTICLE 7. GENERAL ASSISTANCE

R6-13-701. State General Assistance Program

A. Unemployability. A person may qualify for the state. General Assistance Program (GA) on the basis of unemployability due to medical disability alone, or medical disability in combination with social disability, or as a caretaker for a disabled person.
   1. Medical disability is defined as inability to engage in substantial gainful employment by reason of a medically determinable physical or mental impairment which ~~has lasted, or~~ is expected to last~~,~~ at least 12 months ~~30 continuous days~~ from the date of the GA application. An individual shall not be considered to be disabled for purposes of this Section when alcoholism or drug addiction is a contributing factor that the individual is disabled.
   2. Substantial gainful employment is defined as any work of a nature generally performed for remuneration or profit, involving the performance of significant physical or mental duties, or a combination of both.
   3. Social disability is defined as any nonmedical impairments or deficiencies -- such as advanced age, lack of education, or employment history -- which, in combination with medical disability, would further serve to limit employability.
   4. For GA eligibility purposes, a person shall be considered unemployable due to disability in a calendar month in which any of the criteria listed in subsections (B) is ~~or (C) are~~ met.
   5. Provided all eligibility factors are met, assistance shall be granted for months in which any of the unemployability criteria in subsections (B) is~~, (C), or (D) are~~ met beginning from the date of application up to and including the full calendar month in which the unemployability ends.

B. ~~Categorical medical disability. A person is categorically considered to be medically disabled if any of the criteria listed below are met either singly or in combination. If so,~~
   ~~1. The determination of disability can be made by the Family Assistance Administration (FAA) local office, and~~
   ~~2. There is no need to secure further medical verification or to refer the case to the District Medical Consultant (DMC) for a determination, and~~
   ~~3. There is no need to consider social disability factors:~~
      ~~a. RSDI Disability. The person is determined by the Social Security Administration (SSA) to be eligible for Retirement, Survivors, Disability Insurance (RSDI) benefits based on disability.~~
      ~~b. SSI. The person is determined by SSA to be eligible~~

~~for Supplemental Security Income (SSI) on the basis of disability.~~

e. ~~VA. The person is determined by the Veterans Administration (VA) to have at least a 50% disability whether or not service related.~~

d. ~~Drug and alcoholic rehabilitation. The person is residing in a clinic or center and is engaged in a drug abuse rehabilitation or alcoholic detoxification or rehabilitation program provided that repayment is either required or will be accepted in part or in full by the rehabilitation clinic or center.~~

e. ~~Vocational rehabilitation. The person is both~~
   i. ~~An eligible VR client and~~
   ii. ~~Is currently under an Individual Written Rehabilitation Plan (IWRP) of the Arizona state VR Agency.~~

f. ~~Hospitalized. The person is hospitalized in any hospital, whether public or private, for any physical or mental ailment.~~
   i. ~~However, the person is not GA eligible if the hospital meets the person's basic needs of shelter, food and medication.~~
   ii. ~~As an exception to the provision above, a person in a hospital which meets the person's basic needs may receive GA for not more than three months if paying rent or mortgage to retain a residence which to return to after release.~~

g. ~~Conditional release. The person has been released from a hospital and the physician has imposed work restrictions during a specified recuperation period, or certifies the person is permanently disabled.~~

h. ~~Termination of employment. The person has been required, either by the employer or by a physician, to terminate employment due to the onset of a disability, and a physician has specified a recuperation period or certifies the person is permanently disabled.~~ Whether the disability is job-related, or whether the person is capable of the employment is immaterial.

i. ~~Pregnancy. The woman is in her last trimester of pregnancy and does not meet the qualifications for Aid to Families with Dependent Children (AFDC) Pregnancy benefits.~~

j. ~~Sheltered workshop. The person is employed in a sheltered workshop, or deemed capable of working only in a sheltered workshop.~~

k. ~~Prior certification. The person, at the time of application or reapplication, has in his case record a prior certification of disability, either by the Department, SSA or VA, which is still currently valid. The certification may be for a specified duration, or for permanent disability so long as it covers the current months for which assistance is requested and received.~~

~~C.~~B. Medical and social disability. ~~If a person does not meet any of the categorical criteria in subsection (B) above, the~~ A person may qualify for assistance on the basis of at least one medical disability, either physical or mental, in combination with one or more social disability factors.

1. Medical disability factors. The medical disability factors ~~factor(s) do not need to be of the same severity as required for categorical eligibility in subsection (B) above but~~ shall constitute the primary cause of the person's unemployability. The medical factors, in combination with the social disability factors, shall cause the person to be unemployable -- that is, incapable of engaging in substantial gainful employment.
2. Social disability factors. Any social disability factors, which, in combination with medical disability factors, would further serve to render the person unemployable shall be considered by the Department. These include but are not limited to:
   a. Age,
   b. Education,
   c. Employment history,
   d. English (ability to speak or understand spoken English),
   e. Literacy (ability to read or write English)
3. Determinations. Determinations ~~in this category~~ shall ~~not~~ be made by the FAA local office ~~or but only~~ by the District Medical Consultants ~~in consultation with employment and rehabilitation specialists of the Department~~. In making these determinations the Department shall consider whether the person is able to engage in any employment for which he could qualify, whether his last job, or any prior job, or any other job, he could do within his residual capabilities, and which currently exists in the national economy. If so, the person shall be determined employable. If not, he shall be determined unemployable.

~~D.~~C. Caretakers. A person may qualify for GA as an unemployable caretaker if the person is required to remain in the home to give care to a disabled person. The need for such care shall be verified by a physician.

~~E.~~ ~~Homemakers. A person may qualify for GA as a disabled homemaker if the person meets any of the criteria listed in subsections (B), (C), or (D) above, irrespective of prior work history. That is, a person is not disqualified from GA assistance solely because the person has never been employed or self-employed.~~

~~F.~~D. Employment while disabled. A person deemed unemployable shall not be disqualified from assistance solely because the person continues or takes up gainful employment while being considered for or while receiving GA assistance. Any earnings shall be considered on the budget to determine financial eligibility.

~~G.~~E. Acceptance of medical treatment. A person is not required, as a condition of GA eligibility, to accept treatment recommended by examining physicians or medical consultants of the Department.

~~H.~~F. Referral to and cooperation with Vocational Rehabilitation (VR). A person is not required, as a condition of GA eligibility, to accept referral to, or cooperate with VR. A person may be referred VR by examining physicians or by medical consultants of the Department, or may voluntarily request referral.

~~I.~~G. Application for RSDI or SSI. A person ~~who is found by the Department to meet the disability criteria for RSDI or SSI~~ shall, as a condition of GA eligibility, with the exception of caretakers, apply for RSDI or SSI ~~such~~ benefits.

~~J.~~ ~~Citizenship and alienage. To receive GA a person shall either be a U.S. citizen, or an alien legally admitted for permanent residence, or otherwise residing in the U.S.A. under color of law.~~

~~K.~~H. ~~Arizona residency. To receive GA, a person shall be a resident of Arizona.~~ A ~~resident is a~~ person establishes Arizona residency by ~~who~~:
   1. ~~is~~ Residing in Arizona, and
   2. An intent ~~intends~~ to continue residence in Arizona.

~~L.~~I. Social Security Numbers (SSN). As a condition of GA eligibility, a person shall present verification of his/her SSN or apply for an SSN. If for any reason SSA cannot grant an SSN

to an SSN applicant, this shall not adversely affect GA eligibility.

J.M. Assets and resources. (Limitations on assets and resources are listed A.R.S. § 46-233(A)(5)).

K.N. Age. GA shall not be granted to any person under age 18. There is no maximum age limit.

L.O. Members of AFDC assistance units. GA shall not be granted to any person who meets the description of an AFDC assistance unit member as defined in A.C.R.R. R6-3-320(F)(1) and R6-3-407. This same restriction applies regardless of whether the person is AFDC eligible or ineligible for the month.

M.P. Reservation Indians. GA cannot be granted to a reservation Indian residing on his own or any other Indian reservation. Reservation Indians shall be referred to BIA for assistance. However, Indians residing off-reservation may receive GA.

N.Q. Redeterminations. A redetermination (review of all eligibility factors subject to change) shall be conducted no less often than once every 6 months counting from the 1st month of eligibility. However, a review of unemployability factors in subsection ~~subsections~~ (B), ~~(C) or (D)~~ shall be conducted upon the expiration of the certification period as indicated by the physician or the District Medical Consultant of the Department. Once it is determined by the Department that a person is unemployable per subsection ~~subsections~~ (B), ~~(C) or (D)~~ for 6 months or more, such a determination shall not be reversed unless it is based upon substantial new evidence not considered by the prior District Medical Consultant.

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 27. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) HEALTH CARE FOR PRIVATE EMPLOYER GROUPS/AHCCCS ADMINISTERED

PREAMBLE

1. Sections Affected / Rulemaking Action

R9-27-101	Amend
R9-27-201	Amend
R9-27-202	Amend
R9-27-203	Amend
R9-27-204	Amend
R9-27-205	Amend
R9-27-206	Amend
R9-27-207	Amend
R9-27-208	Amend
R9-27-209	Amend
R9-27-210	Amend
R9-27-211	Repeal
R9-27-301	Amend
R9-27-302	Amend
R9-27-303	Amend
R9-27-304	Amend
R9-27-305	Amend
R9-27-306	Amend
R9-27-307	Amend
R9-27-308	Amend
R9-27-309	Amend
R9-27-310	Amend
R9-27-401	Amend
R9-27-402	Amend
R9-27-403	Amend
R9-27-404	Amend
R9-27-405	Amend
R9-27-406	Amend
R9-27-407	Amend
R9-27-408	Repeal
R9-27-501	Amend
R9-27-502	Amend
R9-27-503	Amend
R9-27-504	Amend
R9-27-505	Amend
R9-27-506	Amend

R9-27-507	Amend
R9-27-508	Repeal
R9-27-509	Amend
R9-27-510	Amend
R9-27-511	Amend
R9-27-512	Amend
R9-27-513	Amend
R9-27-514	Amend
R9-27-515	Amend
R9-27-516	Amend
R9-27-601	Repeal
R9-27-601	New Section
R9-27-701	Amend
R9-27-702	Amend
R9-27-703	Amend
R9-27-704	Amend
R9-27-705	Amend
R9-27-801	Amend

2. **The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**

   Authorizing statute: A.R.S. § 36-2912(G)(6)

   Implementing statutes: A.R.S. §§ 36-2901(4)(a), (b), (c), (h), and (j), and 36-2912(A) through (G)

3. **The name and address of agency personnel with whom persons may communicate regarding the rules:**

   Name: Cheri Tomlinson
   AHCCCS Administration

   Address: Office of Policy Analysis and Coordination
   801 East Jefferson, Mail Drop 4200
   Phoenix, Arizona 85034

   Telephone: (602) 417-4781

   Fax: (602) 256-6756

4. **An explanation of the rules, including the agency's reasons for initiating the rules:**

   The proposed rule changes are necessary to:

   1) Comply with the provisions set forth in A.R.S. § 36-2912(G)(6), which requires the Healthcare Group of Arizona rules to stand alone and not be dependent upon references to the AHCCCS Administration rules.

   2) Add definitions as they apply to subject matter discussed elsewhere within the rules.

   3) Change the program name from Health Care Group to Healthcare Group of Arizona, the program name which is registered with the Secretary of State.

   4) Clarify the pre-existing condition limitations and portability requirements as specified in A.R.S. § 36-2912(I) (credits to members who had continuous coverage).

   5) Grammatical changes.

   6) Clarify and make the grievance and appeal rule language consistent with actual practice.

5. **A showing of good cause why the rules are necessary to promote a statewide interest if the rules will diminish a previous grant of authority of a political subdivision of this state:**

   Not applicable.

6. **The preliminary summary of the economic small business and consumer impact:**

   a. The statutory requirement of A.R.S. § 36-2912(G)(6) which requires Healthcare Group of Arizona to promulgate separate rules and to not be dependent upon references to rules adopted by AHCCCS will not have an economic impact to the HCG customers. However, removing references to the AHCCCS rules, and rewriting the rules as they apply to the HCGA, will be beneficial to HCG customers. Currently, the health plans contracting with HCGA also contract with AHCCCS. In the past, there has been some confusion as to which rules pertain to only AHCCCS and which pertain to the HCGA. The rule changes included in this packet will clarify this issue.

   b. There will be a slight to moderate economic impact to the HCG Plans in complying with the pre-existing condition limitations and portability requirements of A.R.S. § 36-2912(I). The HCG Plans are now required to provide coverage to individuals with pre-existing conditions, if the individuals meet the portability requirements of the law. The law requires that the Plans provide a credit of one month for each month of continuous coverage, of 60 days or more, the member had through another contracted health plan or accountable health plan.

c. The name change from Health Care Group to Healthcare Group of Arizona will not have an economic impact on small businesses and consumer groups. The HCG Plans have been marketing the HCG product under the new name and have revised their stationary items and marketing materials to reflect the change.

d. Clarifying the HCG Plans responsibility in paying for in-patient and out-patient hospital services and emergency ambulance services to in-state and out-of-state providers of service will not have an economic impact to small businesses and consumers. However, the changes made will be beneficial to the HCGA, HCG Plans and providers by reducing the number of grievances providers file pertaining to this subject matter.

e. The economic impact of providing the HCGA the flexibility to address the amount of copayment(s) a HCG Plan could charge a member would be minimal to small businesses and consumers. However, in order to stay in business HCGA must be competitive with other commercial carriers. HCGA will continue to monitor and establish the copayment amounts in accordance with the industry standards.

7. **The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:**

Name:	Cheri Tomlinson AHCCCS Administration
Address:	Office of Policy Analysis and Coordination 801 East Jefferson, Mail Drop 4200 Phoenix, Arizona 85034
Telephone:	(602) 417-4781
Fax:	(602) 256-6756

8. **The time, place, and nature of the proceedings for the adoption, amendment, or repeal of the rule; or, if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:**

A public hearing will be held as follows;

Date:	April 9, 1997
Time:	9 a.m. to 12 p.m.
Location:	AHCCCS Administration Hearing Room A, 2nd Floor 701 East Jefferson Phoenix, Arizona

A person may submit written comments on the proposed rules. The written comments should be submitted no later than 5 p.m., April 8, 1997, to the person listed above.

9. **Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:**

Not applicable.

10. **Incorporations by reference and their location in the rules:**

Section 1163 of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), 9 U.S.C. 1163, October 21, 1986, in R9-27-407.

11. **The full text of the rules follows:**

TITLE 9. HEALTH SERVICES

CHAPTER 27. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) HEALTH CARE FOR PRIVATE EMPLOYER GROUPS/AHCCCS ADMINISTERED

ARTICLE 1. DEFINITIONS

R9-27-101. Definitions

ARTICLE 2. SCOPE OF SERVICES

R9-27-201. Scope of services ~~Covered services provided to enrolled members~~
R9-27-202. Covered Services
R9-27-203. Excluded Services
R9-27-204. Out-of-service Area Coverage
R9-27-205. Outpatient Health Services
R9-27-206. Laboratory, X-ray, and Medical Imaging Services
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ARTICLE 1. DEFINITIONS

R9-27-101. Definitions

The following words and phrases, in addition to definitions contained in A.R.S. Title 36, Chapter 29, have the following meanings unless the context explicitly requires another meaning:

1. "AHCCCS" means the Arizona Health Care Cost Containment System.
2. ~~"AHCCCS hearing officer" means a person designated by the Director to preside over administrative hearings regarding eligibility appeals and grievances.~~
2.3. "Ambulance" means any motor vehicle licensed pursuant to the Department of Health Services and A.R.S. Title 36, Chapter 21.1, especially designed or constructed, equipped and intended to be used, maintained and operated for the transportation of persons requiring ambulance services.
3. "Clean Claim" means one that can be processed without obtaining additional information from the provider of the service or from a 3rd party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.
4. "Coinsurance" ~~coinsurance~~ means a predetermined amount a member agrees to pay to a provider for covered services. A coinsurance payment is a calculated percentage of the fee schedule rate for the services.

5. ~~4.~~ "Copayment" means a monetary amount specified by the Healthcare ~~Health Care~~ Group Administration which the member or dependent pays directly to a provider at the time covered services are rendered.
6. ~~5.~~ "Covered services" means those health and medical services described in R9-27-202 ~~Article 2~~ of these rules.
7. ~~6.~~ "Day" means a calendar day unless otherwise specified in the text.
8. "Deductible" means the fixed annual dollar amount a member agrees to pay for certain covered services before the Healthcare Group Plan agrees to pay.
9. ~~7.~~ "Dependent ~~subscriber or dependent~~" means the eligible spouse and children of the employee member pursuant to R9-27-303 of these rules.
10. "Eligible employee" means an employee that is eligible for Healthcare Group coverage pursuant to R9-27-302.
11. ~~8.~~ "Emergency ambulance service" means:
    a. Transportation ~~Emergency transportation~~ by a licensed ambulance or air ambulance company for ~~of~~ persons requiring emergency medical services. ~~services.~~
    b. Emergency medical services that ~~which~~ are provided before, during, ~~during~~ or after such transportation by a person certified by the Department of Health Services to provide such services. ~~ambulance operator or attendant~~.
12. ~~9.~~ "Emergency medical services" means medical services provided after the sudden onset of ~~for~~ a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
    a. Placing the patient's health in serious jeopardy;
    b. Serious impairment to ~~of~~ bodily functions; or
    c. Serious dysfunction of any bodily organ or part.~~; or~~
    c. Death
13. ~~10.~~ "Employer group" means the aggregate enrollment of an employed group or business that ~~which~~ is contracting with a Healthcare ~~Health Care~~ Group Plan for covered services.
14. ~~11.~~ "Employee member" means an enrolled employee ~~member~~ of an employer group.
15. ~~12.~~ "Enrollment" means the process by which an employer group or member applies for coverage and contracts with a Healthcare ~~Health Care~~ Group Plan.
16. ~~13.~~ "Full-time employee" means an employee who works at least 20 hours per week and expects to continue employment for at least 5 ~~five~~ months following enrollment.
17. ~~14.~~ "Grievance" means a complaint arising from an adverse action, decision, or policy by a HCG Plan ~~plan~~, subcontractor, noncontracting ~~noncontracting~~ provider or the Healthcare Group Administration, presented by an individual or entity as specified by R9-27-601 ~~Article 6 of these rules.~~
18. ~~15.~~ "Group Service Agreement (GSA)" means a ~~the~~ contract between an ~~the~~ employer ~~Employer~~ group and a ~~the~~ Healthcare Group ~~Health Care Group~~ Plan.
19. ~~16.~~ "Healthcare ~~Health Care~~ Group of Arizona (HCG)" means the registered name of the Healthcare Group Program, which is a prepaid medical coverage product marketed by the HCG Plans to small uninsured businesses and political subdivisions within the state. ~~medical coverage offered by Healthcare Group Plans to employer groups.~~
20. ~~17.~~ "Healthcare Group Administration (HCGA)" ~~Health Care Group Management (HCGM)~~ means the Section within AHCCCS ~~the Administration~~ that directs and regulates the continuous development and operation of the HCG Program. ~~will administer the Health Care Group.~~
21. ~~18.~~ "Healthcare ~~Health Care~~ Group Plan (HCG Plan or Plan)" means a prepaid health plan ~~participating in The Health Care Group~~ that ~~which~~ is currently under contract with the HCGA ~~Administration~~ to provide ~~AHCCCS~~ covered services. ~~In AHCCCS contracts for the provision of state-assisted care, Plans are referred to as "Contractors."~~
22. ~~19.~~ "Hospital" means a health care institution licensed as a hospital by the Department of Health Services under ~~pursuant to~~ A.R.S. Title 36, Chapter 4, Article 2, ~~as a hospital,~~ and certified as a provider under Title XVIII of the Social Security Act, as amended, or is determined by AHCCCS ~~the Administration~~ to meet the requirements for ~~of such~~ certification under Title XVIII of the Social Security Act, as amended.
23. "Inpatient hospital services" means medically necessary services which require an inpatient stay in an acute care hospital. Inpatient hospital services are provided by or under the direction of a physician or other health practitioner upon referral from a member's primary care provider.
24. ~~20.~~ "Life threatening" means any condition for which a ~~the time~~ delay in ~~of~~ obtaining pre-authorization and subsequent travel to an approved medical facility would have a severe adverse effect on the patient's condition.
~~21. "Long Term Care Services" means those services, including nursing services that are ordinarily provided in a nursing care institution, licensed supervisory care facility and adult certified care facility, except for the services specified in R9-22-202.~~
25. "Medical record" means a single, complete record kept at the site of the member's primary care provider which documents the medical services received by the member, including inpatient discharge summary, outpatient, and emergency care.
26. ~~22.~~ "Medical services" means services pertaining to medical care that is ~~are~~ performed at the direction of a physician, on behalf of members by physicians, nurses, ~~nurses~~ or other health practitioners ~~related professionals~~ and technical personnel.
27. ~~23.~~ "Medically necessary" means those covered services provided by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law to:
    a. Prevent disease, disability, and other adverse health conditions or their progression; or
    b. Prolong life.
28. ~~24.~~ "Member" means an ~~the Health Care Group~~ employee ~~member~~ or dependent ~~dependents~~ who is enrolled with a HCG Plan.
29. "Noncontracting provider" means a provider who renders covered services to a member but who does not have a subcontract with the member's HCG Plan.
30. "Other health practitioner" means a person other than a physician who is licensed or certified under Arizona law to deliver health care services.
31. "Outpatient services means medically necessary services that may be provided in any setting on an outpatient basis (does not require an overnight stay in an inpatient hospital). Outpatient services are provided by or under the

direction of a physician or other health practitioner, upon referral from a member's primary care provider.

~~25. "Outpatient health services" means those preventive, diagnostic, rehabilitative, or palliative items or services which are ordinarily provided in hospitals, physician's offices and clinics, by licensed health care providers by or under the direction of a physician or practitioner, to an outpatient.~~

32. ~~26.~~"Pharmaceutical services" means medically necessary drugs prescribed by a primary care physician, a practitioner, or other physician, ~~physician~~ or dentist upon referral by a primary care provider ~~physician~~ and dispensed in accordance with R9-27-207.

33. ~~27.~~"Physician services" means services provided within the scope of practice of medicine or osteopathy as defined by state law or by or under the personal supervision of an individual licensed under state law to practice medicine or osteopathy. ~~osteopathy and excludes those services routinely performed and not directly related to the medical care of the individual patient, e.g., physician visits to a long term care facility for purposes of 30-60 day certification.~~

34. "Political subdivision" means a full-time officer or employee of the state of Arizona or of a county, city, town or school district within the state under A.R.S. § 36-2901.

35. "Practitioner" means a physicians' assistant or a registered nurse practitioner who is certified and practicing in an appropriate affiliation with a physician, as authorized by law.

36. "Pre-existing condition" means an illness or injury that has been diagnosed or treated within the 12-month period preceeding the effective date of coverage.

37 ~~28.~~"Premium" means the monthly prepayment submitted to HCGA ~~Health Care Group Management~~ by the employer group.

38 ~~29.~~"Pre-payment" means submission of the employer group's premium payment 30 days in advance of the effective date of coverage in accordance with R9-27-306. ~~an arrangement in which a contractor agrees to provide health care services for a prospective, predetermined, periodic, fixed subscription premium.~~

39. ~~30.~~"Prescription" means an order to a provider for covered services, which is signed or transmitted by a provider licensed under applicable state law to prescribe or order such services.

40. ~~31.~~"Primary care provider" ~~physician~~ means a primary care physician or a primary care practitioner. ~~physician who provides medical services at the patient's point of entry into the health care system and coordinates the patient's medical care with necessary specialists and other health professionals.~~

41. ~~32.~~"Prior authorization" means the process by which the HCG ~~Health Care Group~~ Plan authorizes, ~~will determine~~ in advance, ~~advance~~ the delivery of ~~whether a~~ covered services. ~~service, that requires prior approval, will be reimbursed.~~

42. ~~33.~~"Quality management" ~~Assurance~~ means a methodology used by professional health personnel to ~~that~~ assess ~~assesses~~ the degree of conformance to desired medical standards and practices; and activities designed to continuously improve and maintain quality service and care, performed through a formal program with involvement of multiple organizational components and committees.

43. ~~34.~~"Referral" means the process whereby a member is directed by a primary care provider ~~physician~~ to another appropriate provider or resource for diagnosis or treatment.

44. ~~35.~~"Rider or Contract rider ~~Rider~~" means an amendment to the group service agreement between an ~~the~~ employer group ~~Employer Group~~ and a HCG ~~Health Care Group~~ Plan.

45. ~~36.~~"Scope of services ~~Services~~" means the ~~those~~ covered, limited and excluded services set forth in R9-27-201 through R9-27-210. ~~Article 2 of these rules.~~

46. ~~37.~~"Service area ~~Area~~" ~~or Area~~ means the geographic area designated by HCGA ~~the Administration~~ wherefore ~~within which~~ each HCG ~~Health Care Group~~ Plan shall provide covered health care benefits to members ~~Members~~ directly or through subcontracts.

47. "Spouse" means the husband or wife of a HCG member who has entered into a marriage recognized as valid by the state of Arizona.

48. ~~38.~~"Subcontract" means an agreement entered into by a HCG ~~Health Care Group~~ Plan with any of the following:
   a. A provider of health care services who agrees to furnish covered services to members; ~~members.~~
   b. A marketing organization; ~~organization.~~ and
   c. Any other organization.

49. "Subscriber" means an enrolled employee of an employer group.

50. ~~39.~~"Subscriber Agreement" means a ~~the~~ contract between an ~~the~~ employee member and HCG ~~Health Care Group~~ Plan.

~~40. "Tier" means the level of coverage (single, single plus one, or family) in which premiums are structured.~~

51. ~~41.~~"Utilization control" means the overall accountability program encompassing quality management ~~assurance~~ and utilization review.

52. "Utilization review" means a methodology used by professional health personnel to assess the medical indications, appropriateness, and efficiency of care provided.

ARTICLE 2. SCOPE OF SERVICES

R9-27-201. Scope of Services ~~Covered services provided to enrolled members~~

A. Each HCG Plan shall provide, either directly or through subcontracts, the covered services specified in this Article.

B. Covered services shall be provided by, or under the direction of, a primary care provider. ~~physician. Nurse practitioners and physician assistants may provide covered services in affiliation with a primary care physician.~~

C. The scope of covered services and excluded services may be further delineated or limited in the Group Service Agreement.

R9-27-202. Covered Services

A. Subject to the exclusions and limitations specified in these rules, the following services shall ~~will~~ be ~~normally~~ covered:
   1. Outpatient services; ~~health services.~~
   2. Laboratory, ~~Laboratory and~~ X-ray and medical imaging services;
   3. Prescription drugs; ~~drugs.~~
   4. Inpatient hospital services; ~~services.~~
   5. Emergency medical services ~~service~~ in and out of the service area; ~~area.~~
   6. Emergency services; ~~ambulance.~~and
   7. Maternity care.

B. The scope of covered services may be expanded or reduced through a rider to the group service agreement with the prior written consent of the HCGA. ~~Administration~~

C. Any medical service not specifically provided for in this Article or in a rider is not a covered service.

R9-27-203. Excluded Services

The following services shall not be ~~are not~~ covered:

1. Services or items furnished solely for cosmetic purposes; ~~purposes.~~
2. Services or items requiring prior authorization for which prior authorization has not been obtained; ~~obtained.~~
3. Services or items furnished gratuitously or for which charges are not usually made; ~~made.~~
4. Hearing aids, eye examinations for prescriptive lenses, and prescriptive lenses; ~~lenses.~~
5. Long-term care services, including nursing services; ~~services.~~
6. ~~Services of private~~ Private or special duty nurses, ~~nurses~~ services provided ~~except when medically necessary~~ in a hospital and prior authorized by the Plan Medical Director ~~Director.~~ when medically necessary;
7. Care for health conditions that ~~which~~ are required by state or local law to be treated in a public facility; ~~facility.~~
8. Care for military service disabilities treatable through governmental facilities ~~services~~ if the member is legally entitled to such treatment and facilities are reasonably available; ~~available.~~
9. Gastric stapling or diversion for weight loss; ~~loss.~~
10. Reports, evaluations, or physical examinations not required for health reasons including, but not limited to, employment, insurance, or governmental licenses, and court-ordered forensic or custodial evaluations; ~~evaluations.~~
11. Treatment of temporomandibular joint dysfunction, unless such treatment is prior authorized and determined by the Plan Medical Director or ~~his~~ designee to be essential to the health of a member; ~~member, and is authorized by the Plan Medical Director or his designee~~
12. Elective abortions; abortions.
13. Medical and hospital care and costs for the child of a dependent, ~~Dependent Subscriber~~ unless such child is otherwise eligible under the Agreement; ~~Agreement.~~
14. Nonmedical ~~Nonmedical~~ ancillary services including vocational rehabilitation, employment counseling, psychological counseling and training, and physical therapy for learning disabilities; ~~disabilities.~~
15. Sex change operations and reversal of voluntarily induced infertility (sterilization); ~~(sterilization).~~
16. Care not deemed medically necessary by the Plan Medical Director, or the responsible primary care provider, ~~physician~~ and not specifically provided for in the HCG ~~Health Care Group~~ covered services; ~~services.~~
17. Allergy testing and hyposensitization treatment; ~~treatment.~~
18. Routine foot care; ~~care.~~
19. Blood and blood products; ~~products.~~
20. Surgery that ~~which~~ is not medically necessary; ~~necessary.~~
21. Human organ transplants, except for cornea and kidney transplants; ~~transplants.~~
22. Mental health services; ~~services.~~
23. Durable medical equipment; ~~equipment.~~
24. Artificial implants; ~~health implants.~~
25. Dental services; ~~services.~~
26. Transportation other than emergency ambulance services; ~~services.~~
27. Psychotherapeutic drugs; ~~drugs.~~
28. Charges for injuries incurred as the result of participating in a riot, or committing, or attempting to commit a felony or assault, or by suicide attempt; ~~attempt.~~
29. Early and periodic screening, diagnosis, and treatment services (EPSDT); ~~(EPSDT).~~ and
30. In vitro fertilization.

R9-27-204. Out-of-service area coverage

Coverage out-of-area ~~out of area~~ is limited to emergencies for members traveling or temporarily outside of their HCG ~~Health Care Group~~ Plan's service area in accordance with R9-27-209(B).

R9-27-205. Outpatient Health Services

The HCG Plans shall provide the ~~The~~ following outpatient ~~health~~ services: ~~to be provided by Health Care Group Plans are as follows:~~

1. Ambulatory surgery and anesthesiology services not specifically excluded; ~~excluded.~~
2. Physician's services; ~~services.~~
3. Pharmaceutical services and prescribed drugs to the extent authorized by these rules, ~~rules~~ and applicable provider contracts; ~~contracts.~~
4. Laboratory services; ~~services.~~
5. Radiology ~~X-ray~~ and medical imaging services; ~~services.~~
6. Services of other ~~allied~~ health professionals when supervised by a physician; ~~physician.~~
7. Nursing services provided in an outpatient health care facility; ~~facility.~~
8. The use of emergency, examining, or treatment rooms when required for the provision of physician's services; ~~services.~~
9. Home physician visits, ~~visits~~ as medically necessary, ~~necessary.~~
10. Specialty care physician services referred by a primary care provider; ~~physician.~~
11. Physical examinations, periodic health examinations, health assessments, physical evaluations, or diagnostic work-ups that include tasks or procedures to
    a. Determine risk of disease; ~~disease.~~
    b. Provide early detection of disease;~~.~~
    c. Detect the presence of injury or disease at any stage; ~~stage.~~
    d. Establish a treatment plan for injury or disease at any stage; ~~stage.~~
    e. Evaluate the results or progress of a treatment plan or treatment decision; ~~decision,~~ or
    f. Establish the presence and characteristics of a physical disability that ~~which~~ may be the result of disease or injury; ~~injury.~~ and
12. Short-term rehabilitation and ~~physical~~ therapy which, in the judgment of the Plan Medical Director or ~~his~~ designee, can be expected to result in the significant improvement of a member's condition within a period of 2 ~~two~~ months after ~~from~~ the initial ~~treatment.~~ rehabilitation or therapy treatment.

R9-27-206. Laboratory, X-ray and Medical Imaging Services

The HCG Plans shall provide laboratory ~~Laboratory~~, X-ray and medical imaging services prescribed by the member's ~~a~~ primary care provider, ~~physician practitioner or physician upon referral from the primary care physician,~~ which are ordinarily provided in hospitals, clinics, physicians' offices and other health facilities by licensed health care providers, ~~providers shall qualify as covered service~~ if medically necessary. Clinical laboratory, X-ray, or medical imaging service providers must satisfy all applicable state and federal license and certification requirements and shall provide only services that ~~which~~ are within the categories stated in such provider's license or certification.

R9-27-207. Pharmaceutical Services

A. The HCG Plans shall ensure that pharmaceutical ~~Pharmaceutical~~ services are ~~shall be~~ available to members during customary business hours. Such services ~~hours and~~ shall be located

within reasonable travel distance ~~distance.~~ within the Plan's service area.

B. The following limitations shall apply:
1. Drugs personally dispensed by a physician or dentist are not covered, except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed.
2. Prescription drugs shall ~~will~~ be prescribed ~~covered~~ up to a 30-day supply unless the ~~HCG Health Care Group~~ Plan determines a longer supply is more cost effective.
3. Immunosuppressant (anti-rejection) drugs are covered except when prescribed as part of the post-operative treatment for noncovered ~~noncovered~~ organ transplants. However, if a member ~~or dependent~~ is taking such drugs at the time of enrollment as part of the post-operative treatment for any ~~ANY~~ organ transplant, the ~~such~~ drugs are not covered.
4. Only ~~those~~ drugs which are not available over-the-counter are covered.

R9-27-208. Inpatient Hospital Services

A. ~~Inpatient hospital services means medically necessary services provided by or under the direction of a primary care physician, practitioner or by a specialty physician on referral from a primary care physician.~~ The HCG Plans shall provide the following inpatient hospital services: ~~provided by Health Care Group Plans shall be as follows~~
1. Routine services, including:
   a. Hospital accommodations; ~~accommodations,~~
   b. Intensive care and coronary care units ;~~unit,~~
   c. Nursing services necessary and appropriate for the member's medical condition; ~~condition ,~~
   d. Dietary services; ~~,~~
   e. Medical supplies, appliances, ~~appliances~~ and equipment ordinarily furnished to hospital inpatients billed as part of routine services, ~~services~~ and included in the daily room and board charge; ~~charge,~~ and
2. Ancillary services, including:
   a. Labor, delivery and recovery rooms, and birthing centers; ~~centers,~~
   b. Surgery and recovery rooms; ~~rooms,~~
   c. Laboratory services; ~~services,~~
   d. Radiological and medical imaging services; ~~services,~~
   e. Anesthesiology services; ~~services.~~
   f. Rehabilitation services; ~~services,~~
   g. Pharmaceutical services and prescribed drugs; ~~drugs,~~
   h. Respiratory therapy; ~~therapy,~~
   i. Maternity services; ~~services,~~
   j. Nursery and related services; ~~services,~~
   k. Chemotherapy; ~~Chemotherapy,~~ and
   l. Dialysis as limited by these rules.

B. Limitations. The following limitations shall apply: ~~to inpatient hospital services provided by Health Care Group Plans:~~
1. Inpatient hospital accommodations are limited to no more than a semi-private rate, except when patients must be isolated for medical reasons.
2. Dialysis is limited to services not covered by Title XVIII, of the Social Security Act, as amended.
3. Alternative levels of care in lieu of hospitalization shall ~~will~~ be covered when determined cost effective and medically necessary by the Plan's ~~Plan~~ Medical Director, ~~Director~~ or ~~his~~ designee.

R9-27-209. Emergency Medical Services

A. Emergency medical services provided within the Plan's service area. ~~In-Area emergency services.~~ Emergency medical services shall be ~~in-area emergency are~~ available to members 24-hours-a-day ~~24 hours a day~~, 7-days-a-week ~~seven 7 days a week. In-area emergency services shall be pre-authorized by Health Care Group Plan providers except in the case of life threatening emergencies in which the member has no control over the hospital to which he is taken. In this instance,~~ The ~~the~~ Plan shall ~~must~~ be notified within 24 hours after the initiation of treatment. Failure to provide timely notice constitutes cause for denial of payment.

B. ~~Out-of-area emergency~~ Emergency medical services provided outside the Plans which cannot be postponed until the member is able to return to the service area ~~for treatment without risking serious complications~~ are covered. The Plan must ~~shall~~ be notified within 48 hours after the initiation of treatment ~~for a covered service~~. Failure to provide timely notice constitutes cause for denial of payment.

C. Ambulance services.
1. Within the Plan's service area. A member shall be ~~is~~ entitled to emergency ambulance services ~~service~~ within the Plan's service area. ~~Emergency ambulance services shall be pre-authorized by the Plan, except in the case of a life threatening emergency in which case~~ The ~~the~~ Plan must be notified within 24 hours. Failure to provide timely notice constitutes cause for denial of payment.
2. Outside the Plan's service area. A member shall be ~~is~~ entitled to ambulance services ~~service~~ outside the service area to transport the member to the nearest medical facility capable of providing required emergency services. ~~service~~ The Plan must be notified within 48 hours. Failure to provide timely notice constitutes cause for denial of payment.

R9-27-210. Pre-existing Conditions

~~A. A pre-existing condition is an illness or injury which has been diagnosed or treated within the 12 month period preceding the effective date of coverage. Coverage shall not be provided for inpatient services related to a pre-existing condition for 12 months from the effective date of coverage.~~

A. A HCG Plan shall not provide for inpatient services related to a pre-existing condition for 12 months from the effective date of coverage.

B. ~~Pregnancy as a pre-existing condition.~~ A HCG Plan shall not cover inpatient ~~Inpatient~~ costs for the delivery of a child ~~shall not be covered~~ for 10 ~~ten~~ months from the effective date of coverage. ~~For the purpose of coverage and payment, complications of pregnancy shall be treated as new medical conditions and shall not be subject to the pre-existing condition limitation.~~

C. A HCG Plan shall not impose a pre-existing condition exclusion against an eligible employee who meets the following standards:
1. Newborns from the time of their birth;
2. Eligible employees who meet the portability requirements of A.R.S. § 20-2308:
   a. A person who had continuous coverage for a 1-year period and during that year had no breaks in coverage totaling more than 31 days; and
   b. The person's prior coverage ended within 60 days before the date of application for enrollment.
3. A HCG Plan shall give a credit of 1 month for each month of continuous coverage that an eligible employee had under another HCG Plan or accountable health plan in accordance with A.R.S. § 36-2912. Upon request, a contracted health plan or an accountable health plan

which provided continuous coverage to an individual shall promptly disclose the coverage provided.

~~R9-27-211. Minimum Health Care Benefits, Additional Services, and Charges~~
~~Each Health Care Group Plan shall provide, directly or through subcontracts, not less than the covered services specified in these rules.~~

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

R9-27-301. Eligibility Criteria for Employer Groups

A. An ~~All~~ employer group ~~groups~~ shall be conducting business within the state of Arizona for at least 60 days prior to making application. This shall be determined by 1 or more of the following:
   1. Participation in state unemployment insurance; ~~insurance;~~
   2. Participation in state worker's compensation; ~~compensation;~~
   3. Possession of a state tax identification number; ~~number;~~ and
   4. Other verifiable proof that the applicant is conducting a business in the state of Arizona.

B. An employer group ~~Employer groups~~, other than the state of Arizona and political subdivisions of the state, shall have a minimum of 1 ~~one~~ and a maximum of 40 full-time employees at the effective date of its ~~their~~ 1st contract with a HCG ~~Health Care Group~~ Plan. Acceptable proof of the number of full-time employees may include canceled ~~cancelled~~ checks, bookkeeping records, and personnel ledgers.

C. Other than state employees and employees of political subdivisions of the state, 50% of the eligible employees in a group must enroll in order for the employer group to contract with a HCG ~~Health Care Group~~ Plan. Employees with proof of other medical coverage who do not wish to participate in the HCG ~~Health Care Group~~ shall not be considered in determining the percentage.

D. Changes in group size that occur during the term of the Group Service Agreement shall ~~will~~ not affect eligibility.

R9-27-302. Eligibility Criteria for Employee Members

A. Employee members shall reside, work, or reside and work in ~~be residents of~~ the state of Arizona.

B. Employee members shall be employed by an eligible employer group as specified ~~described~~ in R9-27-301.

C. Employee members shall have been employed at least ~~for~~ 60 consecutive days prior to the effective date of coverage.

D. Employee members or self-employed persons shall ~~must~~ work for the employer group at least 20 hours per week, with anticipated employment of at least 5 ~~five~~ months following enrollment.

R9-27-303. Eligibility Criteria for Dependents

A. Eligible dependents of employee members include:
   1. A legal spouse; ~~spouse.~~ and
   ~~2. A natural child, adopted child, step-child, a child supported by the employee member pursuant to a valid court order, or a child for whom the employee member is a legal guardian. Such children shall be under the age of 19 or under the age of 24 if a full time student.~~
   2. Unmarried children under the age of 19 or under the age of 24 if a full-time student:
      a. Natural child;
      b. Adopted child;
      c. Step-child;
      d. Child supported by the employee member pursuant to a valid court order;
      e. Child for whom the employee member is a legal guardian; and
   3. A child incapable of self-sustaining support by reason of mental or physical disability ~~handicap~~ existing ~~prior~~ ~~to~~ ~~his~~ before the child's 19th birthday, as determined by the Plan Medical Director or ~~his/her~~ designee.

~~4.~~ B. Limitations.
~~No service or benefits under the Health Care Group will be extended to the~~ A grandchild of an employee member shall be eligible to receive covered services only if, ~~unless~~ the grandchild meets the eligibility requirements of R9-27-303(A)(2). ~~paragraph (2) of this Section.~~

R9-27-304. Employer Group Member Eligibility Verification ~~group and employee member eligibility verification~~

A. The HCG ~~Health Care Group~~ Plan shall determine the eligibility status of the employer group and ~~employee~~ members ~~member~~.

B. Eligibility verification may be conducted at random or for cause by the HCGA ~~Health Care Group Management~~ or HCG ~~Health Care Group~~ Plan.

R9-27-305. Health History Form

Prior to enrollment, all eligible employees ~~employee potential members~~ and dependents shall complete the HCG health history form. An eligible employee or dependent ~~A potential member~~ shall not be denied enrollment as a result of conditions described on the health history form. However, a pre-existing condition will limit the benefits available to a ~~the~~ member. Failure to provide complete and accurate information on the Health History Form ~~this form~~ is cause for immediate termination ~~termination.~~ from the HCG Plan.

R9-27-306. Effective Date of Coverage

Employer groups shall submit payment 30 days in advance of the effective date of coverage; the effective date of coverage shall be the 1st day of the month for which the premium has been pre-paid ~~is paid~~.

R9-27-307. Open Enrollment of Employee Members

A. Enrollment of employee members shall occur only during 1 ~~one~~ of the following open enrollment periods:
   1. Thirty days following the effective date ~~initial signing~~ of the Group Service Agreement; ~~Agreement . by the employer group.~~
   2. A 30-day period to start 60 days from the date of employment for a new employee in an enrolled employer group, or a 30-day period after the completion of an employer's waiting period on eligibility for health care coverage, whichever ~~time~~ period is greater; ~~greater .~~ and
   3. Thirty days following the acquisition of a new dependent.
   ~~3.~~ 4. A 30-day period to begin 105 days and conclude at least 75 ~~45~~ days before the employer group's renewal date, ~~date~~ as determined by the HCGA. ~~the Administration~~.

B. Enrollment of new dependents shall occur within the 30 day period following the acquisition of a new dependent and in accordance with R9-27-308 if the dependent is a newborn.

R9-27-308. Enrollment of Newborns ~~Newborn eligibility~~

All newborns shall be enrolled within 30 days of birth to be eligible for coverage. Upon enrollment, the newborn's premium is due to the HCGA within 30 days of birth for coverage retroactive to the 1st day of the month in which the birth occurred.

R9-27-309. Enrollment of Newly eligible Employee and Dependent Due to Loss of Own Coverage ~~Newly eligible dependent due to loss of own coverage~~

A. Eligible employee due to loss of own coverage. An eligible employee, who had health care through a spouse, shall be eli-

gible to enroll as a member within 30 days of the loss of coverage, if that loss of separate coverage was due to:

1. Death of the eligible employee's spouse,
2. Divorce, or
3. Termination of employment of the eligible employee's spouse.

B. Eligible dependent due to loss of own coverage. An eligible dependent, ~~dependent~~ who had individual or family coverage separate from the member's coverage and who loses that coverage due to termination of employment or retirement, ~~retirement~~ may enroll as a dependent member ~~subscriber~~ within 30 days of the loss of coverage.

R9-27-310. Denial and Termination of Enrollment ~~Reasons for denial of enrollment~~

A. An employer group, employee, ~~or employee,~~ or dependent ~~member~~ who fails to meet the requirements of this Article shall be denied enrollment.

B. Termination of enrollment and coverage for an employer group, employee member, or dependent shall occur on the last day of the month in which:

1. The employer group loses eligibility;
2. The employee member loses eligibility; and
3. The dependent loses eligibility.

C. The HCG Plan may exclude employer groups or employee members from enrollment who have committed fraud or misrepresentation while enrolled with another HCG Plan or health benefits carrier.

ARTICLE 4. CONTRACTS, ADMINISTRATION, AND STANDARDS

R9-27-401. General

A. Contracts to provide services under the HCG program ~~Health Care Group~~ shall be established between the HCGA ~~Administration~~ and qualified HCG ~~AHCCCS~~ Plans in accordance ~~in conformance~~ with the applicable provisions ~~requirements~~ set forth in this Article and A.R.S. Title 41, Title 36, and Title 20. Rules promulgated shall apply to such contracts, except if there is a conflict between the HCG rules and applicable statutes, in which event the statutes shall take precedence.

B. Contracts and subcontracts entered into under ~~in accordance with~~ this Article shall become public records on file with the HCGA unless otherwise made confidential by law. ~~Administration.~~

R9-27-402. Contracts

A. In order to ~~have a~~ contract with the HCGA, ~~Administration to provide services under the Health Care Group,~~ a health plan must meet the requirements of A.R.S. § 36-2912, ~~have a current AHCCCS contract to provide state-assisted care~~

B. Each contract shall be in writing and ~~shall~~ contain, ~~contain~~ at a minimum, ~~least~~ the following information:

1. Full disclosure of the method and amount of compensation or other consideration to be received by the HCG ~~Health Care Group Plan; Plan.~~
2. Identification of the name and address of the HCG ~~Health Care Group~~ Plan; ~~Plan.~~
3. Identification of the population and geographic service area to be covered by the contract; ~~contract.~~
4. The amount, duration, ~~duration~~ and scope of medical services to be provided, or for which compensation will be paid; ~~paid.~~
5. Specification of the term of the contract, including the beginning and ending dates, as well as methods of extension, re-negotiation, ~~renegotiations~~ and termination; ~~termination.~~
6. A provision that the HCG ~~Health Care Group~~ Plan arrange for the collection of any required copayment, coinsurance, deductible ~~copayment~~ and 3rd party insurance; ~~insurance.~~
7. A provision that the HCG Plan will not bill or attempt to collect from a ~~the~~ member for any covered service except as may be authorized by statute, these rules, ~~rules~~ or contract riders ~~Contract Riders~~ that ~~which~~ have been approved by the HCGA; ~~Administration.~~
8. A provision that the contract will not be assigned or transferred without the prior written approval of the HCGA; ~~Administration.~~
9. ~~A provision that specifies~~ Procedures ~~procedures~~ for enrollment of the covered population; ~~population.~~
10. ~~A provision that specifies~~ Procedures ~~procedures~~ and criteria for terminating or suspending the contract; ~~contract.~~ and
11. A provision that the HCG Plan will ~~An agreement to~~ hold harmless and indemnify the state, AHCCCS, HCGA ~~Health Care Group Management~~, ~~the Administration~~ and members against claims, liabilities, judgments, costs, ~~costs~~ and expenses with respect to 3rd parties, which may accrue against the state, AHCCCS, HCGA ~~Health Care Group Management~~, ~~the Administration~~ or members, through the negligence or other action of the HCG Plan ~~contractor~~.

R9-27-403. Subcontracts

A. Approval. Any subcontract entered into by a HCG ~~Health Care Group~~ Plan to provide covered services to HCG ~~Health Care Group~~ members is subject to review and approval of the HCGA. ~~Administration~~ No subcontract alters the legal responsibility of the HCG Plan ~~contractor~~ to the HCGA ~~Administration~~ to ensure ~~assure~~ that all activities under the contract are carried out.

B. Subcontracts. Each subcontract shall be in writing and include:

1. A specification that the subcontract will ~~shall~~ be governed by and construed pursuant to ~~in accordance with~~ all laws, rules, ~~rules~~ and contractual obligations of the HCG ~~Health Care Group~~ Plan.
2. A provision that the HCG Plan will ~~An agreement to~~ notify the HCGA ~~the Health Care Group Management~~ in the event the subcontract ~~agreement~~ with the HCG ~~Health Care Group~~ Plan is amended or terminated.
3. A provision ~~An agreement~~ that assignment or delegation of the subcontract is ~~shall be~~ void unless prior written approval is obtained from the HCGA ~~Administration~~.
4. An agreement to hold harmless the state, ~~Health Care Group Management,~~ AHCCCS, the HCGA, ~~Administration~~ and members in the event the HCG ~~Health Care Group~~ Plan is unable to or does not pay for covered services performed by the subcontractor.
5. A provision that the subcontract and subcontract amendments are subject to review and prior written approval by the HCGA ~~Administration as set forth in these rules~~ and that a subcontract or subcontract amendment may be terminated, rescinded, ~~rescinded~~ or canceled ~~cancelled~~ by the HCGA ~~Administration~~ for violation of a provision ~~the provisions~~ of these rules.
6. An agreement to hold harmless and indemnify the state, ~~Health Care Group Management,~~ AHCCCS, the HCGA, ~~Administration~~ and members against claims, liabilities, judgments, costs and expenses with respect to 3rd parties, which may accrue against the state, AHCCCS, the HCGA, ~~Health Care Group Management, the Adminis-~~

~~tration~~ or members, through the negligence or other action of the subcontractor.

7. Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor.
8. The amount, duration, ~~duration~~ and scope of medical services to be provided, ~~provided~~ by the subcontractor, ~~or~~ for which compensation will be paid.

C. A HCG Plan may submit a written request to the HCGA ~~Administration~~ requesting a waiver of the requirement that the a Plan subcontract with a hospital in the Plan's service area. The request shall state ~~set forth~~ the reasons for requesting a waiver ~~therefor~~ and ~~shall state~~ all efforts that have been made to secure ~~such~~ a subcontract with a hospital within the Plans service area. For good cause shown, the HCGA ~~Administration~~ may waive the hospital subcontract requirement. The HCGA ~~Administration~~ shall consider the following criteria in deciding whether to waive the hospital subcontract requirement:

1. The number of hospitals in the service area; ~~area.~~
2. The extent to which the HCG Plan's primary care ~~providers physicians~~ have staff privileges at noncontracting ~~noncontracting~~ hospitals in the service area; ~~area.~~
3. The size and population of, and the demographic distribution within, the service area; ~~area.~~
4. The patterns ~~Patterns~~ of medical practice and care within the service area; ~~area.~~
5. Whether the HCG Plan has diligently attempted to negotiate a hospital subcontract in the service area; ~~area.~~
6. Whether the HCG Plan has any ~~hospital~~ subcontracts in adjoining areas with hospitals that are reasonably accessible to the Plan's members in the service area; ~~area.~~ and
7. Whether the HCG Plan's members can reasonably be expected to receive all covered services in the absence of a hospital subcontract.

R9-27-404. Contract ~~amendments; mergers; reorganizations~~

Any merger, reorganization, ~~reorganization~~ or change in ownership of a HCG ~~Health Care Group~~ Plan or subcontractor affiliated with the HCG Plan shall constitute a contract amendment. The HCG Plan shall obtain ~~which requires the~~ prior written approval from ~~of~~ the HCGA ~~Administration~~. Prior to ~~Additionally~~, any merger, reorganization, ~~reorganization~~ or change in ownership of a HCG Plan or subcontractor that is related to or affiliated with the HCG Plan, ~~Health Care Group Plan shall constitute a contract amendment which requires prior written approval~~ of the HCGA ~~Administration~~ To be effective, contract amendments shall be submitted in ~~reduced~~ ~~to~~ writing to the HCGA and executed by both parties.

R9-27-405. Contract Termination

A. Contract between the HCGA ~~Administration~~ and HCG ~~Health Care Group~~ Plan. The HCGA ~~Administration~~ may suspend, deny, refuse, fail to renew, or terminate a contract or require the HCG Plan to terminate a subcontract for good cause which may include the following reasons:

~~1. Failure of the Health Care Group Plan to receive and maintain an AHCCCS contract for the provision of state-assisted care.~~

1. ~~2.~~ Submission of any misleading, false or fraudulent information; ~~information.~~
2. ~~3.~~ Provision of any services in violation of or not authorized by licensure, certification, or other law; ~~law.~~
3. ~~4.~~ A material breach of contract; ~~contract.~~
4. ~~5.~~ Failure to provide and maintain quality health care services to members, as determined by standards established by the state; ~~state.~~ and
5. ~~6.~~ Failure to reimburse a medical provider ~~providers~~ within 60 days, ~~days~~ of receipt of a clean ~~valid~~ claim ~~claims~~ unless a different period is specified by contract.

B. Group Service Agreement ~~Contract~~ between HCG ~~Health Care Group~~ Plan and employer group.

1. The GSA ~~contract~~ may be terminated with written notice from either the HCG Plan or employer to the other party no more than 60 days, and at least 45 days prior to the Anniversary date of ~~or~~ the GSA. ~~Agreement~~
2. The GSA ~~contract~~ may be terminated by the HCG Plan for cause with 10 ~~45~~ days' written notice for the following:
   a. Material misrepresentation of information furnished by the employer to the Plan.
   b. Employer's ~~For employer's~~ default in payment of premiums time being of the essence.
3. The GSA ~~contract~~ may be terminated by the employer group or ~~on~~ the HCG Plan with 45 days' written notice for a material breach of the contract.

C. Termination of an ~~Contract between the~~ employee member by the HCGA or HCG Plan ~~and Health Care Group Plan.~~

1. Cause for immediate termination of coverage. The ~~Health Care Group Administration~~ HCGA or HCG ~~Health Care Group~~ Plan may terminate an employee members coverage ~~of an employee member immediately~~ for the following:
   a. Fraud or misrepresentation when applying for coverage ~~the Subscriber Agreement~~ or obtaining services; or
   b. Violence, or threatening or other substantially abusive behavior ~~Violence and threatening behavior~~ toward the HCGA or the HCG Plans' employees, or agents, or contracting or noncontracting providers or their employees or agents.
2. Cause for termination with 30 days written notice. The ~~Health Care Group Management~~ HCGA or the ~~Health Care Group~~ HCG Plan may terminate coverage of an employee member for the following reasons:
   a. Repeated and unreasonable demands for unnecessary medical services;
   b. Failure to pay any copayment, coinsurance, deductible, ~~copayment~~ or required financial obligation; and
   c. Material violation of any provision of the Group Service Agreement.
3. Termination by reason of ineligibility.
   a. Termination of employment, ~~.~~
   b. Failure of employer or employee to pay premium. Termination shall be effective the 1st day of the month for which the premium has not been paid, ~~.~~
   c. Coverage of a dependent member shall automatically cease on the last day of the month in which the dependent member ~~terminates employment and~~ loses coverage, for any reason, as described in R9-27-406 and R9-27-407, ~~or upon the death or divorce of the member subsequent to continuation and conversion coverage: under Article 4 of these rules~~
   d. Subject to continuation coverage and conversion coverage, ~~coverage~~ as described in R9-27-406 and R9-27-407, ~~under Article 4 of these rules,~~ on the effective date of termination of coverage, the HCG Plan shall have no further obligation to provide services and benefits to a ~~the~~ member whose coverage has been ~~so~~ terminated; except that a member confined to a hospital at the effective date of termination shall continue to receive coverage ~~under the Agreement~~ until there has been a determination by the

HCG Plan Medical Director or ~~his~~ designee that care in the hospital is no longer medically necessary for the condition for which the member was admitted to the hospital; ~~.~~ and

e. An employee member whose coverage terminates pursuant to this subsection ~~Subsection~~ shall ~~will~~ not be eligible for re-enrollment until the employer group's next open enrollment period. ~~enrollment.~~ The employee shall meet all the eligibility criteria prescribed by these rules prior to re-enrollment.

D. The HCG Plan may exclude employer groups or employee members from enrollment who have committed fraud or misrepresentation while enrolled with another HCG Plan or health benefits carrier.

R9-27-406. Continuation Coverage

Employer groups with at least 20 employees on a typical business day during the preceding calendar year shall provide continuation coverage as required by Sections 10001 and 10002 of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), 29 U.S.C. 1161 et seq., incorporated by reference herein, ~~herein~~ and on file with the Office of the Secretary of State. The employer group shall collect the premium from the employee and pay the premium to HCGA ~~the Administration~~.

R9-27-407. Conversion Coverage

This Section applies only to employee members, spouses, and dependents ~~and employee members~~ of employer groups with fewer than 20 employees.

1. An enrolled employee member, spouse, dependent, or a qualified beneficiary who loses eligibility for ~~any reason other than for cause~~ a qualifying event, as defined in Section 1163 of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), and who has been covered for at least 3 ~~three~~ months under the GSA ~~employer group enrollment~~ may convert the policy to an individual policy for a period of 180 days. ~~All dependents covered at the time of the employee member's loss of eligibility may also be covered under the conversion policy. The spouse or dependents may convert upon the death or divorce of the employee member.~~
2. A member shall have 30 days after the ~~end~~ date of termination of group coverage to convert the coverage and pay the initial premium. Any services used within the ~~that~~ 30-day conversion period prior to payment of the initial premium shall not be covered unless the care was provided or authorized by the member's primary care provider ~~physician~~ or the HCG Plan.
3. A member shall pay the ~~The~~ premium for the converted coverage ~~shall be paid~~ directly to the HCGA ~~Administration and~~ Converted coverage shall be retroactive to the ~~end~~ date of termination of group coverage.

~~**R9-27-408. Contracting**~~

~~Contracts to provide services under the Health Care Group shall be awarded in accordance with the provisions of R9-22-601 et seq. The Arizona Procurement Code, A.R.S. § 41-2501 et seq., and rules promulgated thereunder shall also apply to contracts between Plans and the Administration, except to the extent that they are inconsistent with these rules or A.R.S. Title 36, Chapter 29.~~

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

R9-27-501. Availability and Accessibility of Services

HCG ~~Health Care Group~~ Plans shall ensure that an ~~provide available, accessible and~~ adequate number ~~numbers~~ of institutional facilities, service locations, and service sites, professional, allied and paramedical personnel are available and accessible for the provision of covered services, including ~~all~~ emergency medical services ~~care on a 24-hours-a-day, 7-days-a-week. 24 hours a day, 7 days a week basis.~~ The HCG ~~Health Care Group~~ Plan shall have or provide the following, at ~~as~~ a minimum:

1. A designated emergency medical services facility, providing care ~~on a 24-hours-a-day, 7-days-a-~~ week. ~~24 hours a day, 7 days a week basis. basis,~~ Emergency Medical Services facilities shall be accessible to members in each contracted service area. With 1 ~~One~~ or more physicians and 1 ~~one~~ nurse ~~shall be~~ on call or on duty at such facility at all times.
2. An emergency medical services system employing at least 1 ~~one~~ physician, registered nurse, physician's assistant or nurse practitioner, shall be accessible to members by telephone 24-hours-a-day, 7-days-a-week, ~~week basis,~~ to provide ~~for more~~ information ~~in the event of an emergency, as defined by these rules, and~~ to providers who need verification of patient membership and treatment authorization; ~~authorization.~~ and in the case of an emergency as defined under emergency medical services in R9-27-101.
3. An emergency medical services call log that contains the following information:
   a. Member's name,
   b. Member's address,
   c. Member's telephone number,
   d. Date of call,
   e. Time of call,
   g. Instructions given to each member.

~~3. An emergency services call log containing: member's name, address, telephone number, date of call, time of call, nature of complaint or problem, and instructions given each member.~~

4. A written procedure plan for the communication of emergency medical services information to the member's primary care provider ~~physician~~ and other appropriate organizational units.
5. An appointment system for each of the HCG Plan's ~~its~~ service locations. The appointment system shall ensure ~~assure~~ that:
   a. Members with acute or urgent problems are ~~shall be~~ triaged and provided same-day service when necessary; ~~necessary,~~
   b. Time-specific appointments for routine medically necessary care from the primary care provider ~~physician~~ are ~~shall be~~ available within 3 ~~three~~ weeks of a member's request and on the same day for emergency care;, and
   c. Referral appointments to specialists are ~~in must be~~ the same day for emergency care, within 3 ~~three~~ days for urgent care, ~~care~~ and within 30 days for routine care.
6. One primary care provider an enrolled member may select or to whom the member may be assigned. HCG Plans whose organization does not ordinarily include primary care providers shall enter into affiliation or subcontract with an organization or individuals to provide such primary care. The HCG Plans shall agree to provide services under the primary care provider's guidance and direction. The primary care provider is responsible for:
   a. Supervising, coordinating, and providing initial and primary care to patients;
   b. Initiating referrals for speciality care; and
   c. Maintaining continuity of patient care.

~~6. One primary care physician who an enrolled member may select or to whom the member may be assigned. This physician is responsible for supervising, coordinating and providing initial and primary care to patients; initiating referrals for specialty care; and maintaining continuity of patient care. Health Care Group Plans whose organization does not ordinarily include primary care physicians shall enter into affiliation or subcontract with organizations or individuals to provide such primary care; the Health Care Group Plans shall agree to provide services under the primary care physician's guidance and direction.~~

a. Supervising ~~supervising~~, coordinating, and providing initial and primary care to patients;

b. Initiating ~~initiating~~ referrals for specialty care; and

c. Maintaining ~~maintaining~~ continuity of patient care. ~~Health Care Group Plans whose organization does not ordinarily include primary care physicians shall enter into affiliation or subcontract with organizations or individuals to provide such primary care; the Health Care Group Plans shall agree to provide services under the primary care physician's guidance and direction.~~

7. Primary care physicians and specialists providing inpatient services to members must have staff privileges in a minimum of 1 ~~one~~ general acute care hospital under subcontract with the contracting health plan, within or near the service area of the HCG ~~Health Care Group~~ Plan.

R9-27-502. Reinsurance

A. Reinsurance may be provided by the HCGA ~~Health Care Group Management~~ through private reinsurers. ~~No state funds shall be used to pay premiums or otherwise reinsure members.~~

B. For purposes of the HCGA's ~~Health Care Group Management~~ reinsurance program, the insured entities shall ~~will~~ be the HCG ~~Health Care Group~~ Plans with which the HCGA ~~Administration~~ contracts.

1. A specified amount per member, ~~member~~ per month ~~month~~ shall ~~will~~ be deducted by the HCGA ~~Health Care Group Management~~ from the HCG ~~Health Care Group~~ Plan's monthly premium to cover the cost of the reinsurance contract.
2. The HCG Plan shall ~~be responsible for~~ comply ~~comply ing~~ with the reimbursement requirements of the reinsurance agreement between the reinsurer and the HCGA ~~Administration~~.

R9-27-503. Marketing; Prohibition Against Inducements, Misrepresentation, Discrimination, Sanctions

A. Marketing representatives shall not misrepresent themselves, the HCG ~~Health Care Group~~ Plan or the HCG ~~AHCCCS~~ program through false advertising, false statements, ~~statements~~ or in any other manner in order to induce members of other contracting entities to enroll in a particular HCG Plan ~~given health plan~~. ~~1.~~ Violations of this subsection shall include, but not be limited to, false or misleading claims, inferences or representations that:

~~1.~~ ~~a.~~ Marketing representatives may be ~~are~~ employees of the state or representatives of the HCGA ~~Administration~~, a county, ~~county~~ or HCG ~~any~~ health plan other than the HCG ~~health~~ plan with whom they are employed or by whom they are reimbursed.

2. The HCG Plan ~~health plan~~ is recommended or endorsed as superior to its competition by any state or county agency or any other organization which has not certified its endorsement in writing to such HCG Plan ~~health plan~~ and the HCGA ~~Administration~~.

B. Marketing representatives shall not engage in any marketing or other pre-enrollment practices that discriminate against an eligible person or member because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual preference, physical or mental disability ~~handicap~~, or health status.

C. HCG ~~Health Care Group~~ Plans shall bear responsibility for the performance of any marketing representative, subcontractor or agent, program or process under their employ or direction.

R9-27-504. Approval of Advertisements and Marketing Material

A. HCG Plans ~~Health Care Group Plans~~ shall submit to the HCGA for review and approval proposed advertisements, marketing strategies, ~~and~~ materials and paraphernalia ~~shall be reviewed and approved by the Health Care Group Management~~ prior to distributing such ~~distribution of~~ materials or implementing any ~~implementation of~~ activities.

B. HCG Plans shall submit all ~~All~~ proposed materials and strategies ~~shall be submitted~~ in writing to the HCGA ~~Health Care Group Management~~

C. The HCGA ~~Health Care Group Management~~ ~~will~~ shall review and approve or disapprove all materials and strategies. ~~strategies for approval or disapproval~~. The HCGA shall notify the HCG Plan in writing of the approval or disapproval of the marketing materials and strategies. A notice of disapproval shall include ~~will be accompanied by~~ a statement of objections and recommendations.

D. To minimize the expense of revising advertising or other copy, a HCG Plan may submit the material ~~may be submitted~~ in draft form subject to final approval and filing of a proof or final copy.

E. HCG Plans shall submit 2 ~~Two~~ copies of the proof or final approved copy of materials to the HCGA which shall, maintain ~~shall be submitted to and maintained by~~ the proof or copy for 5 years. ~~the Health Care Group Management~~.

R9-27-505. Member Records and Systems

Each HCG ~~Health Care Group~~ Plan shall maintain a member service record that shall ~~will~~ contain encounter data, grievances, complaints, and service information for each member.

R9-27-506. Fraud or Abuse

All HCG ~~Health Care Group~~ Plans, providers, ~~providers~~ and non-providers shall advise the HCGA ~~Health Care Group Management~~ immediately in writing of suspected fraud or abuse.

R9-27-507. Release of Safeguarded Information

A. Information to be safeguarded concerning applicants or members of the HCG ~~Health Care Group~~ includes ~~include~~:

1. Names, addresses, ~~addresses~~ and social security numbers; ~~numbers.~~
2. Evaluation of personal information; ~~information,~~ and
3. Medical data and services including diagnosis and ~~past~~ history of disease or disability.

B. Unrestricted information. The restrictions upon disclosure of information shall not apply to summary data, ~~statistics~~ utilization data, and other information that does not ~~which do not~~ identify an individual applicant or member.

C. Safeguarded ~~The use or disclosure of~~ information concerning a member shall be disclosed only ~~limited~~ to:

1. The member, or applicant or in the case of a minor, the member ~~member's~~ or applicant's parent or guardian,
2. Individuals authorized by the member, and
3. Persons or agencies for official purposes. Safeguarded information may be released to these parties only under the conditions specified in subsections (D), (E), and (F). ~~in this Section~~

D. A ~~The~~ member or authorized representative may view the member's ~~his or her~~ medical record after written notification to the provider and at a reasonable time and place.

E. Release to individuals authorized by the individual concerned. The HCG Plan shall release medical ~~Medical~~ records and any other HCG ~~Health Care Group~~ related confidential information of members or applicants ~~applicants or members may be released~~ to individuals authorized by the member or applicant only under the following conditions:
   1. A notarized authorization ~~Authorization~~ for release of information must be obtained from the member, applicant, ~~member~~ or authorized representative. In the case of a minor, the member or applicant's parent, custodial relative, or guardian shall submit a notarized authorization for release of information.
   2. Authorization used for release of information must be submitted in writing ~~a written document~~, separate from any other document, and must specify the following:
      a. Information or records, in whole or in part, which are authorized for release;
      b. To whom the release shall be made;
      c. The period of time for which the authorization is valid, if limited; and
      d. The dated signature of the member, applicant or authorized representative. In the case of a minor member or applicant, signature of a parent, custodial relative, ~~relative~~ or guardian ~~designated representative~~ is required unless the minor is able ~~capable and sufficiently mature~~ to understand the consequences of authorizing and not authorizing.
   3. If a grievance or appeal has been filed, the grievant, appellant, or designated representative shall be permitted to review, obtain, or copy any nonprivileged record necessary for the proper presentation of the case. The grievant or appellant also may authorize release of safeguarded information deemed necessary to the contested issue, to any opposing party in the case.

F. Release to persons or agencies for official purposes.
   1. Medical record. The HCGA ~~Health Care Group Management~~ may release safeguarded information contained in the member's medical record to law enforcement officials without the member's consent only in ~~situations of~~ suspected cases of fraud and abuse against the HCG ~~Health Care Group~~ program.
   2. Review committees. If there is an ~~For~~ official purpose the HCGA may disclose ~~purposes,~~ safeguarded information, case records, and medical services information may be disclosed without the consent of the member, to ~~members,~~ agents or employees of review committees in accordance with the provisions of A.R.S. § 36-2917.

G. Subcontractors shall not be required to obtain written approval from the member before transmitting member medical records to physicians:
   1. Providing services to members under subcontract with the HCG ~~Health Care Group~~ Plan; or
   2. Retained by the subcontractor to provide services that are infrequently used or are of an unusual nature.

~~**R9-27-508. Filing notices and appeals**~~

~~All notices and appeals or other statements shall be considered filed for the purpose of these rules when received in writing by the Administration.~~

R9-27-509. Information to Enrolled Members

A. Each HCG ~~Health Care Group~~ Plan shall produce and distribute a printed member handbook ~~information~~ to each enrolled member by the effective date of coverage. The member handbook ~~information materials~~ shall ~~be provided in writing. Information materials shall~~ include the following:
   1. A description of all available services and an explanation of any service limitation, and exclusions from coverage or charges for services, when applicable;
   2. An explanation of the procedure for obtaining covered services, including a notice stating the HCG ~~that Health Care Group~~ Plan shall only be liable for services authorized by a member's primary care provider ~~physician~~ or the Plan;
   3. A list of the names, telephone numbers, ~~numbers~~ and service site ~~service site~~ addresses of primary care providers ~~physicians~~ available for selection by the member, and a description of the selection process, including a statement that informs members ~~that~~ they may request another primary care provider, ~~if physician, in the event that~~ they are dissatisfied with their selection;
   4. Locations, telephone numbers, ~~numbers~~ and procedures for obtaining emergency health services;
   5. Explanation of the procedure for obtaining emergency health services outside the HCG ~~Health Care Group~~ Plan's service area;
   6. The causes for which a member may lose coverage;
   7. A description of the grievance procedures;
   8. Copayment, coinsurance and deductible schedules;
   9. Information on the appropriate use of health services and on the maintenance of personal and family health;
   10. Information regarding emergency and medically necessary transportation offered by the HCG ~~Health Care Group~~ Plan; and~~,~~
   11. Other information necessary to use the program.

B. Notification of changes in services. Each HCG ~~Health Care Group~~ Plan shall prepare ~~revise~~ and distribute to members a printed member handbook service guide insert describing any changes ~~that which~~ the HCG ~~Health Care Group~~ Plan proposes to make in services provided or in service locations. The insert shall be distributed to all affected members or family units at least 14 days prior to a planned change. Notification shall be provided as soon as possible when unforeseen circumstances require an immediate change in services, sites, ~~sites~~ or locations.

R9-27-510. Discrimination Prohibition

A. A HCG ~~Health Care Group~~ Plan shall not discriminate against an applicant or member because of race, color, creed, religion, ancestry, marital status, sexual preference, national origin, age, sex or physical or mental disability ~~handicap~~ in accordance with Title VII of the U.S. Civil Rights Act of 1964, 42 U.S.C., Section 2000 D, regulations ~~rules~~ promulgated pursuant thereto, or as otherwise provided by law or regulation. For the purpose of providing covered services ~~service~~ under contract pursuant to A.R.S. Title 36, Chapter 29, discrimination on the grounds of race, creed, religion, ancestry, marital status, age, sex, national origin, sexual preference or physical or mental disability ~~handicap~~ includes, but is not limited to, the following:
   1. Denying a member any covered service or availability of a facility for any reason except as defined in a rider provided under R9-27-202 or for a pre-existing condition as described in ~~Section~~ R9-27-210 ~~R9-27-501~~;
   2. Providing to a member any covered service that ~~which~~ is different, or is provided in a different manner or at a different time from that provided to other HCG ~~Health Care Group~~ members under contract, except where medically indicated;
   3. Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered ser-

vice, or restricting a member in any way in the member's ~~his or her~~ enjoyment of any advantage or privilege enjoyed by others receiving any covered service; and

4. The assignment of times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual preference, or physical or mental disability ~~handicap~~ of the participants to be served.

B. The ~~HCG Health Care Group~~ Plan shall take affirmative action to ensure that members are provided covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, or physical or mental disability ~~handicap~~, except where medically indicated.

R9-27-511. Equal Opportunity

The ~~HCG Health Care Group~~ Plan ~~shall shall,~~ comply with the following equal opportunity employment requirements:

A. State in all solicitations or advertisements for employees placed by or on behalf of the ~~HCG Health Care Group~~ Plan, ~~state~~ that it is an equal opportunity employer, and

B. Send ~~Will send~~ a notice provided by the HCGA, to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding., ~~a notice, to be provided by the Health Care Group Management,~~ The notice shall advise ~~advising~~ the labor union or workers' representative of the ~~HCG Health Care Group~~ Plan's commitment as an equal opportunity employer and shall be posted ~~post copies of the notice~~ in conspicuous places available to employees and applicants for employment.

R9-27-512. Periodic Reports and Information

A. Upon request by the ~~HCGA Administration~~, each ~~HCG Health Care Group~~ Plan shall furnish to the ~~HCGA Health Care Group Management~~ information from its records relating to contract performance.

B. Each ~~HCG Health Care Group~~ Plan shall maintain records to identify separately all ~~HCG Health Care Group~~ related transactions.

R9-27-513. Medical audits

~~Health Care Group Plans shall comply with the requirements set forth in R9-22-522.~~

A. HCGA shall conduct a medical audit of each HCG Plan at least once every 12 months. Unless HCGA determines that advance notice will render a medical review less useful, the HCGA shall notify the HCG Plan approximately 3 weeks in advance of the date of an on-site medical review. HCGA may conduct, without prior notice, inspections of the HCG Plan facilities or perform other elements of a medical review, either in conjunction with the medial audit or as part of an unannounced inspection program.

B. As part of the medical audit, the HCGA may perform any or all of the following procedures:

1. Conduct private interviews and group conferences with:
   a. Members;,
   b. Physicians and other health professionals; and
   c. Members of the HCG Plan's administrative staff including, but not limited to, its principal management persons; and
2. Examine records, books, reports, and papers of the HCG Plan, any management company of the HCG Plan, and all providers or subcontractors providing health care and other services to the HCG Plan. The examination may include, but is not limited to:
   a. The minutes of medical staff meetings,
   b. Peer review and quality of care review records,
   c. Duty rosters of medical personnel,
   d. Appointment records,
   e. Written procedures for the internal operation of the HCG Plan,
   f. Contracts,
   g. Correspondence with members and with providers of health care services and other services to the HCG Plan, and
   h. Additional documentation deemed necessary by the HCGA to review the quality of medical care.

R9-27-514. HCG Plan's Internal Quality Management and Utilization Control System ~~Health care group plan's internal utilization control system~~

~~Healthcare Group Plans shall comply with the requirements set forth in R9-22-522.~~

A. The HCG Plans shall comply with the following quality management and utilization control requirements:

1. Prepare and submit to HCGA for review and approval annually a written quality management plan which includes utilization review. The quality management plan must be designed and implemented with actions to promote the provision of quality health care services.
2. Design and implement procedures for continuously reviewing the performance of health care personnel and the utilization of facilities, services, and costs.
3. Medical records and systems.
   a. Ensure that member's medical records are maintained by the primary care provider, and include a record of all medical services received by the member from the HCG Plan, and its providers, subcontracting and noncontracting.
   b. Ensure that medical records are maintained as follows:
      i. In a detailed and comprehensive manner that conforms to professional medical standards and practices;
      ii. Permits professional medical review and medical audit processes; and
      iii. Facilitates a system for follow-up treatment.
   c. Forward to the HCG Plan, or its designee, within 30 days following termination of a contract between the HCG Plan and a provider medical records or copies of medical records of all members enrolled with the HCG Plan for which services were provided.
4. Develop and implement a program of utilization control methods for hospitals that , at a minimum, include:
   a. Prior authorization of nonemergency hospital admissions;
   b. Concurrent review of inpatient stays, and
   c. Retrospective review of hospital claims to ensure that covered hospital services are not used unnecessarily or unreasonably.

B. The HCG Plan's utilization control system is subject to evaluation by the HCGA to determine cost effectiveness, and to measure whether quality management and utilization review methods are reducing, controlling, or eliminating unnecessary or unreasonable utilization. The HCG Plan may subcontract with an organization or entity designed to conduct activities regarding prior authorization, concurrent review, retrospective review, or any combination of these activities. A subcontract to conduct quality management or utilization review activities is subject to prior approval by the HCGA.

R9-27-515. Continuity of Care

A HCG ~~Each Healthcare Group~~ Plan shall establish and maintain a system to ensure ~~assure~~ continuity of care which ~~shall~~ includes:

1. Referral of members needing specialty health care services;
2. Monitoring of members with chronic medical conditions;
3. Providing hospital discharge planning and coordination including post-discharge care; and
4. Monitoring the operation of the system through professional review activities.

R9-27-516. Financial Resources

A. A HCG ~~Health Care Group~~ Plan shall demonstrate to the HCGA ~~Health Care Group Management~~ that it has adequate financial reserves, administrative abilities, ~~abilities~~ and soundness of program design to carry out its contractual obligations.

B. Contract provisions required by the Health Care Group Management may include, but are not limited to:
   1. The maintenance of deposits,
   2. Performance bonds,
   3. Financial reserves, or
   4. Other financial security.

~~B. Contract provisions required by the Health Care Group Management may include, but are not limited to, the maintenance of deposits, performance bonds, financial reserves or other financial security.~~

ARTICLE 6. GRIEVANCE AND APPEAL PROCESS

~~**R9-27-601. Member Grievances**~~

~~A. A member aggrieved by any adverse decision or action by a Health Care Group Plan, subcontractor, noncontracting provider, nonprovider or Health Care Group Management, may file a grievance and request a hearing as specified in this Section.~~

~~B. Member grievances to Health Care Group Plan.~~
~~1. All grievance filed by members relating to the Health Care Group Plan, subcontractor, noncontracting provider, or nonprovider shall be filed with the member's Health Care Group Plan for review, investigation and resolution in accordance with the grievance requirements of this Subsection and the applicable contract.~~
~~2. All grievances shall be filed in writing with the member's Health Care Group Plan not later that than 35 days after the date of such adverse decision or action.~~
~~3. The Health Care Group Plan shall record and retain sufficient information to identify the grievant, date of receipt and nature of the grievance.~~
~~4. A final decision shall be rendered by the Health Care Group Plan contractor on grievances that involve issues related to continuity or delivery of medical services within 15 days of filing. A final decision shall be rendered by the Health Care Group Plan on all other grievances within 30 days of filing. A copy of the decision by the Health Care Group Plan shall be personally delivered or mailed by regular mail to all parties and shall state the basis for the decision as well as information regarding the individual's right to appeal the decision to Health Car Group Management.~~
~~5. At the time of enrollment, each member shall be given material explaining grievance procedures available through the Health Care Group Plan and through Health Care Group Management.~~

~~C. Member's appeal or grievance to the Health Care Group Management.~~
~~1. Member's may appeal to and request a hearing from the AHCCCS Appeal and Grievance Division if:~~
~~a. the member files a written notice of appeal not more than 15 days after the date of the final decision of the Health Care Group Plan. The date of the final decision shall be the date of personal delivery to the member or the date of mailing.~~
~~b. In the event that a decision was not timely rendered by the Health Care Group Plan in accordance with the provisions of this Section, the member may file a written notice of appeal not more than 60 days after the date the grievance was filed with the Health Care Group Plan, based upon the Health Care Group Plan's failure or refusal to timely decide the grievance in a timely manner.~~
~~c. The member has a grievance against Health Care Group Management and files the grievance not more than 35 days after the date of adverse decision or action by the Health Care Group Management.~~
~~2. If the Appeal and Grievance Division is unable to resolve the appeal to the appellant's satisfaction, a hearing will be scheduled.~~

~~D. AHCCCS Hearing Officer decision.~~
~~1. The Notice of Hearing shall be in accordance with A.R.S. § 41-1061.~~
~~2. The hearing shall be conducted before an AHCCCS Hearing Officer designated by the Director and held in accordance with A.R.S. §§ 41-1061 and 41-1062.~~
~~3. After the conclusion of the hearing, the AHCCCS Hearing Officer shall prepare written findings of fact and conclusions of law and render a recommended decision to the Director.~~

~~E. Decision of the Director. After receipt of the Hearing Officer's recommended decision, the Director shall issue his or her decision in writing, which shall include findings of fact and conclusions of law, and unless otherwise provided by law, personally deliver or mail by certified mail a copy thereof to all parties at their last known residence or place of business. A petition for rehearing or review shall be filed not later than 15 days after the date of the Director's decision. The date of the Director's decision shall be the date of personal delivery to the member or the date of mailing.~~

~~F. Request for rehearing or review.~~
~~1. Unless the Director determines in the decision that good cause exists otherwise, an aggrieved party may petition the Director for rehearing or review of the decision for any of the following causes which materially affects the appellant's rights:~~
~~a. Irregularity in the proceedings of the hearing or appeal whereby the aggrieved party was deprived of a fair hearing or appeal.~~
~~b. Misconduct of a party of the agency,~~
~~c. Newly discovered material evidence, which with reasonable diligence could not have been discovered and produced at the hearing.~~
~~d. That the decision is the result of passion or prejudice, or~~
~~e. That the decision is not justified by the evidence or is contrary to law.~~
~~2. The petition for review or rehearing shall be in writing and shall specify the grounds upon which the petition is based. The Director shall review the sufficiency of the evidence if the petition is made upon the ground that the decision is not justified by the evidence.~~
~~3. The Director may open the decision, order the taking of additional testimony or evidence before the Hearing Officer, amend findings of fact and conclusions of law or make new findings and conclusions, and render a final decision.~~
~~4. The Director's final decision made pursuant to this Subsection shall be a final administrative decision and may~~

~~be reviewed as provided by A.R.S. § 12-901 et seq. the date of the Director's final decision shall be the date of personal delivery to the member or the date of mailing by certified mail.~~

~~G. Failure to submit a grievance and appeal within the time frames specified in this Section shall constitute a failure to exhaust administrative remedies required as a condition to seeking a judicial relief.~~

R9-27-601. Grievances and Appeals

A. The provisions of this Section provide the exclusive manner through which any individual or entity may grieve against the HCGA and/or the HCG Plans in connection with any adverse action, decision, or policy.

B. Definitions. For the purpose of this Article, the following words and phrases have the following meanings:
1. "Appellant" means the individual or entity filing any grievance or appeal pursuant to this Article.
2. "Request for hearing" means an appeal of an adverse eligibility action; an appeal filed after an informal decision has been rendered on a grievance by the HCGA; an appeal of a grievance decision rendered by a HCG Plan; or an appeal filed because a HCG Plan has failed to timely render a grievance decision.
3. "Respondent" means the party responsible for the action being grieved or appealed. In most grievances, the HCG Plan is the respondent.

C. Filing grievances and appeals. Unless provided elsewhere in this Chapter, all grievances and appeals or other statements shall be considered filed when received in writing by the HCGA.

D. Computation of time. In computing any period of time for establishing timeliness of filing grievances and appeals, the period shall commence the day after the act, event, or decision grieved or appealed, and shall include all calendar days and the final day of the period. If the final day of the period is a weekend or legal holiday, the period shall be extended until the end of the next day which is not a weekend or a legal holiday.

E. Direct grievances to the HCGA.
1. A grievance may be filed directly with the HCGA only by HCG Plans of or by individuals or entities grieving an adverse action, decision, or policy actually made or enacted by the HCGA. If the aggrieved adverse action, decision, or policy actually was made by a HCG Plan, the appellant shall 1st file the grievance with the HCG Plan responsible for the decision, policy or action being grieved, so that the HCG Plan may investigate and resolve the grievance in accordance with this Article and any applicable contracts.
2. Except as provided in subsection (E)(3), all written grievances shall be filed with and received by the HCGA not later that 35 days after the date of the adverse action, decision or policy implementation being grieved.
3. Written grievances regarding claim denials shall be filed not more than 12 months after the date of the service for which payment is claimed. If the claim is denied less than 35 days prior to the expiration of the 12-month time period, the dissatisfied party shall have 35 days from the date of the denial to file the grievance.
4. All grievances shall state with particularity the factual and legal basis thereof and the relief requested. Failure to comply with the specificity requirements shall result in the denial of the grievance.
5. The HCGA, in its sole discretion, may investigate the grievance and render a written informal decision prior to scheduling a hearing. A hearing shall be scheduled if any party timely requests a hearing within 15 days of the postmark date of the informal decision.
6. Pending final resolution of a grievance, appeal, or request for judicial review, a grieving HCG Plan shall proceed diligently with the performance of the contract and in accordance with the HCGA, its designee, or the Director's Decision.
7. If a hearing is requested, it shall be conducted pursuant to the provisions set forth herein.

F. Grievances to HCG Plans.
1. Except as provided in subsection (F)(2), all grievances shall be filed with and received by the appropriate HCG Plan not later than 35 days after the date of the adverse action or decision.
2. Written grievances regarding claim denials shall be filed not more than 12 months after the date of the service for which payment is claimed.
3. All grievances shall state with particularity the factual and legal basis and the relief requested. Failure to comply with the specificity requirement shall result in the denial of the grievance.
4. A final decision shall be rendered by the HCG Plan on grievances that involve issues related to continuity or delivery of medical services within 15 days of filing. A final decision shall be rendered by the HCG Plan on all other grievances within 30 days of filing unless the parties agree on a longer period. The decision by the HCG Plan shall be personally delivered or mailed by certified mail to the parties, and it shall state the basis for the decision as well as the appellant's right to appeal the decision to the HCGA. The HCG Plan's final decision shall specify the manner in which an appeal to the HCGA may be filed.
5. The HCG Plan shall record and retain information to identify the appellant, date of receipt and nature of the grievance.
6. At the time of enrollment, HCG Plans shall give to members written information regarding grievance procedures available through the HCG Plan and the HCGA.

G. Appeal of HCG Plan decisions to the HCGA.
1. After 1st grieving to the appropriate HCG Plan, appellants may appeal to and request a hearing from the HCGA or designee if:
   a. The appellant files a written notice of appeal not more than 15 days after the date of the final decision of the HCG Plan, which is the earlier of the date of personal delivery or the postmark date of certified mail; or
   b. If a decision was not timely rendered by the HCG Plan, the appellant files a written notice of appeal based upon the HCG Plan's failure or refusal to timely decide the grievance.
2. The HCGA, in its sole discretion, may investigate the grievance and render a written informal decision prior to scheduling a hearing. A hearing shall be scheduled if any party timely requests a hearing within 15 days of the postmark date of the informal decision.
3. If a hearing is requested, it shall be conducted pursuant to the provisions set forth herein.

H. Appellant's hearing rights.
1. Each appellant shall be afforded those hearing rights as specified in A.R.S. §§ 41-1061 and 41-1062.
2. Each appellant has the right to obtain copies of any relevant documents from the respondent or from the HCGA at the appellant's expense.

3. Each appellant has the right to appear at the hearing and be heard in person, by telephone if available, through a representative designated in writing by the appellant, or to submit to the HCGA a written statement that is signed and notarized prior to the hearing.
4. Each appellant has the right to bring an interpreter to assist at the hearing.
5. Persons who are hearing-challenged according to A.R.S. § 12-242 shall be provided an interpreter by the HCGA.

I. Withdrawal or denial of a request for hearing.
1. The HCGA or designee shall deny a request for hearing and deny a grievance or appeal if a written request for withdrawal is received from the appellant prior to the date of the hearing. The case file shall then be closed.
2. The HCGA or designee may deny a request for hearing and dismiss a grievance or appeal upon written determination if:
a. The request for hearing is untimely;
b. The request for hearing, grievance or appeal is not for a reason permitted pursuant to this Article; or
c. The appeal is otherwise moot.

J. Notice of Hearing. The Notice of Hearing shall be in accordance with A.R.S. § 41-1061 and it shall include a statement detailing how an appellant may request a change in the scheduled hearing date.

K. Postponement.
1. The HCGA or designee by motion may postpone a hearing. When a request for postponement is made, it shall be in writing and received by the HCGA or designee no later than five days prior to the scheduled hearing date. The HCGA or designee may grant a request for postponement on a showing that:
a. There is substantial cause for the postponement, and
b. The cause is beyond the reasonable control of the party making the request.
2. If a postponement is granted, the hearing shall be rescheduled at the earliest practicable date.

L. Failure to appear for hearing. Should any party or representative fail to appear at the hearing without good cause or a postponement, the HCGA or designee may:
1. Proceed with the hearing;
2. Reschedule the hearing with further notice on the motion;
3. Issue a decision based on the evidence of record; or
4. Issue a default disposition.

M. Conduct Hearing. The hearing shall be conducted pursuant to A.R.S. §§ 41-1061 and 41-1062.
1. The hearing shall be conducted in an informal manner without formal rules of evidence or procedure.
2. The HCGA or designee may:
a. Hold prehearing conferences to settle, simplify, or identify issues in a proceeding, or to consider other matters that may aid in the expeditious disposition of the proceeding;
b. Require parties to state their positions concerning the various issues in the proceeding;
c. Require parties to produce for examination those relevant witnesses and documents under their control;
d. Rule on motions and other procedural items;
e. Regulate the course of the hearing and conduct of participants;
f. Establish time limits for submission of motions or memoranda;
g. Impose appropriate sanctions against any individual failing to obey an order under these procedures, which may include:
i. Refusing to allow the individual to assert or oppose designated claims or defenses, or prohibiting that individual from introducing designated matters in evidence;
ii. Excluding all testimony of an unresponsive or evasive witness; and/or
iii. Expelling the individual from further participation in the hearing;
h. Take official notice of any material fact not appearing in evidence in the record, if the fact is among the traditional matter of judicial notice; and
i. Administer oaths or affirmations.

N. Recommended decision. After the conclusion of the hearing, unless the appellant withdraws or the parties stipulate to a settlement, the hearing officer of the HCGA or designee shall prepare written findings of fact and conclusions of law and render a recommended decision to the Director.

O. Decision of the Director.
1. The Director may affirm, modify, or reject the Recommended Decision in whole or in part; may remand a matter to any party or the hearing officer with specific instructions; or make any other appropriate disposition.
2. The Director shall mail by certified mail a copy of the decision to all parties at their last known residence or place of business.

P. Petition for Rehearing or Review.
1. A party dissatisfied with the decision may petition the Director for rehearing or review of the decision for any of the following causes which materially affects the appellant's rights:
a. Irregularity in the proceedings of the hearing or appeal whereby the aggrieved party was deprived of a fair hearing or appeal;
b. Misconduct of a party or the HCGA;
c. Newly discovered material evidence, which with reasonable diligence could not have been discovered and produced at the hearing;
d. That the decision is the result of passion or prejudice; or
e. That the decision is not justified by the evidence or is contrary to law.
2. The petition for rehearing or review shall be filed not later than 15 days after the date of the Director's decision, which is the postmark date of the decision. The moving party shall also send a copy of the petition to all other parties. If a timely petition for rehearing or review is filed, the Director's decision is not a final administrative decision; rather, the Director shall render a Final Decision which is the final administrative decision.
3. The petition for rehearing or review shall be in writing and shall specifically state the grounds upon which it is based. The Director shall review the sufficiency of the evidence if the petition is made upon the ground that the decision is not justified by the evidence.
4. The Director may remand the case to any party; reopen the decision; order the taking of additional testimony or evidence before the hearing officer; amend findings of fact and conclusions of law; make new findings and conclusions; render an amended decision; or deny the petition and affirm the previous decision.
5. The Director, within the time for filing a petition for rehearing or review, may on the own motion order a rehearing or issue an amended decision for any reason for which he or she might have done so upon petition of any party.

Q. Failure to submit a grievance, appeal, request for hearing, or petition for rehearing or review in a timely manner shall con-

stitute a failure to exhaust administrative remedies required as a condition to seeking judicial relief.

ARTICLE 7. STANDARD FOR PAYMENTS

R9-27-701. Scope of the HCGA's Liability; Payments to HCG Plans ~~health care group Management's liability; payments~~ to ~~health care group plans~~

A. The ~~HCGA Health Care Group Management~~ shall bear no liability for the provision of covered services or the completion of a plan of treatment to any member.

B. All payments to ~~HCG Health Care Group~~ Plans shall be made pursuant to the terms and conditions of contracts executed between the ~~HCG Health Care Group~~ Plan and ~~HCGA the Administration and~~ in accordance with these rules.

C. The ~~HCGA Health Care Group Management~~ shall bear no liability for subcontracts ~~that which~~ the ~~HCG Health Care Group~~ Plan executes ~~may execute~~ with other parties for the provision of either administrative or management services, medical services, covered health care services, ~~services~~ or for any other purpose. The ~~HCG Health Care Group~~ Plan shall indemnify and hold the ~~HCGA Health Care Group Management~~ harmless from any and all liability arising from the HCG Plan's subcontracts, ~~these subcontracts~~ The HCG Plan ~~and~~ shall bear all costs of defense of any litigation over such liability and shall satisfy in full any judgment entered against the HCGA arising from a HCG Plan subcontract. ~~Health Care Group Management in such connection.~~ All deposits, bonds, reserves, and security posted pursuant to R9-27-516 shall be held by the ~~HCGA Administration~~ to satisfy the obligations of this Section.

D. Premium payments, less ~~HCGA Health Care Group Management~~ administrative ~~Administrative charges~~ ~~charge~~ and reinsurance fees, shall be paid monthly to those ~~HCG Health Care Group~~ Plans who have either posted required performance bonds or have otherwise provided sufficient security to the ~~HCGA Health Care Group Management~~.

R9-27-702. Prohibition Against Charges to Members

No ~~HCG Health Care Group~~ Plan, ~~or~~ subcontractor, noncontracting provider, or nonprovider reimbursed by a HCG Plan shall charge, submit a claim, demand, or otherwise collect payment from a member or person acting on behalf of a member for any covered service except to collect authorized copayments, ~~copayments~~ coinsurance and deductibles. This prohibition shall not apply if the ~~HCGA Administration~~ determines that the member willfully withheld information pertaining to the member's ~~his~~ enrollment in a Plan. ~~HCG Health Care Group~~ Plans shall have the right to recover from a member that portion of payment made by a 3rd party to the member when such payment duplicates ~~HCG Health Care Group~~ benefits and has not been assigned to the ~~HCG Health Care Group~~ Plan.

R9-27-703. Payments by ~~HCG Health Care Group~~ Plans

A. Payment for covered services. ~~HCG Health Care Group~~ Plans shall pay for all covered services rendered to its ~~their~~ members where such services ~~were have been~~ arranged by its ~~their~~ agents or employees, subcontracting providers, ~~providers~~ or other individuals acting on the ~~HCG Health Care Group~~ Plan's behalf and for which necessary authorization has been obtained.

B. Payment for medically necessary outpatient services. ~~HCG Health Care Group~~ Plans shall reimburse subcontracting and noncontracting ~~nonsubcontracting~~ providers for the provision of covered health care services provided to its members ~~to their members,~~ Reimbursement shall be made within the time period specified by contract between a ~~HCG Health Care Group~~ Plan and a subcontracting entity or within 60 days of receipt of clean ~~valid accrued~~ claims, ~~claims~~ if a time period is not specified.

C. Payment for instate ~~hospital~~ inpatient and outpatient hospital ~~emergency~~ services. ~~HCG Health Care Group~~ Plans shall reimburse instate ~~in-state~~ subcontracting and noncontracting providers for the provision ~~of hospital~~ inpatient and outpatient ~~emergency~~ hospital services rendered at the subcontracted rate, or in the absence of a subcontract, the amount shall be determined in accordance with the reimbursement methodology set forth in A.R.S. § 36-2903(01)(j). ~~lower of negotiated discounted rates or adjusted billed charges, according to the requirements set forth in A.R.S. 36-2904. Health Care Group Plans shall reimburse out-of-state hospitals for the provision of hospital inpatient and emergency services at the lower of negotiated discounted rates or 80% of billed charges.~~

1. ~~HCG Health Care Group~~ Plans shall pay for all emergency care services rendered their members by noncontracting ~~noncontracting~~ providers when such services:
   a. Conform to the definition of emergency medical services as defined in Article 1 and 2 of these rules, and
   b. Conform to the notification requirements set forth in Article 2 of these rules.
2. ~~HCG Health Care Group~~ Plans shall provide written notice to providers ~~claimants~~ whose claims are denied or reduced by the ~~HCG Health Care Group~~ Plan within 30 days of adjudication of such claims. This notice shall include a statement describing the provider's right to:
   a. Grieve the ~~HCG Health Care Group~~ Plan's rejection or reduction of the claim; and
   b. Submit a grievance to the HCGA or its designee ~~AHCCCS Appeal and Grievance Division~~, pursuant to Article 6 of these rules.

D. Payment for out-of-state inpatient and outpatient hospital services. The HCG Plans shall reimburse out-of-state providers for the provision of inpatient and outpatient hospital services at the lower of negotiated discounted rates or 80% of billed charges.

E. Payment for emergency ambulance services. The HCG Plans shall reimburse providers for emergency ambulance services at the lower of negotiated discounted rates or 80% of the billed charges.

R9-27-704. HCG Plan's ~~Capitated Contractor's~~ Liability to Noncontracting and Nonprovider Hospitals for the Provision of Emergency and Subsequent Care to Enrolled Members

A. For purposes of ~~HCG Health Care Group~~ Plan liability, an emergency medical condition shall be subject to reimbursement only until such time as the patient's condition is stabilized and the patient is transferable to a subcontractor, or until the patient is discharged following stabilization subject to the requirements of A.R.S. § 36-2909(E) and Article 2 of these rules.

B. Subject to subsection ~~(A), (A) of this Section, in the event that~~ a member cannot be transferred following stabilization to a facility ~~that which~~ has a subcontract with the ~~HCG Health Care Group~~ Plan of record, ~~record following stabilization, The HCG the Health Care Group~~ Plan shall pay for all appropriately documented medically necessary treatment provided ~~the such~~ member prior to the date of discharge or transfer at the lower of a negotiated discounted rate or prospective tiered-per-diem rate ~~adjusted billed charges,~~ whichever is less.

C. ~~If In the event that~~ a member refuses transfer from a nonprovider or noncontracting hospital to a hospital affiliated with the member's ~~HCG Health Care Group~~ Plan, neither the ~~HCGA Health Care Group Management~~ nor the ~~HCG Health Care Group~~ Plan shall be liable for any costs incurred subsequent to the date of refusal when:

1. Subsequent to consultation with the member's ~~his HCG Health Care Group~~ Plan, the member continues to refuse the transfer, and
2. The member has been provided and signs a written statement of liability, prior to the date ~~of transfer of liability,~~ informing the member ~~him~~ of the medical and financial consequences of such refusal. If the member refuses to sign a written statement, ~~then~~ a statement signed by 2 ~~two~~ witnesses indicating that the member was informed may be substituted.

R9-27-705. Copayments

~~A. Co-payments shall be collected from members and shall fall within the following ranges:~~

~~Outpatient physicians services, including specialist referral authorized by the Plan physician~~	~~$0~~	~~$100~~
~~Prescription drugs~~	~~$0~~	~~$5.00~~
~~Emergency room visit~~	~~$0~~	~~50.00~~

~~B. The exact co-payments will be established in the contract between the Administration and the Plan.~~

~~C. Co-payments may be waived by agreement between the employer group and the Plan.~~

~~D. The Plan shall be responsible for the collection of co-payments.~~

A. Members shall be required to pay a copayment directly to a provider at the time covered services are rendered.

B. The HCGA shall establish the amount of copayment a member shall be charged. The HCGA shall consider the following in determining the amount of copayment:
   1. The impact the amount of the copayment will have on the population served; and
   2. The copayment amount charged by other group health plans or health insurance carriers for particular services.

C. The HCGA shall include the copayment provisions in its contract with a HCG Plan.

D. The HCG Plans shall provide a schedule of the copayments to members at the time of enrollment.

ARTICLE 8. COORDINATION OF BENEFITS

R9-27-801. Priority of Benefit Payment

A. HCG ~~Health Care Group~~ Plans shall coordinate ~~be responsible for the coordination of~~ all 3rd party benefits. Services provided under the HCG ~~health care group~~ are not intended to duplicate other services and benefits available to an employee member.

B. If a member has other coverage, payment for services shall occur in the following order:
   1. A policy, plan, or program that ~~which~~ has no coordination of benefits provision or nonduplication provision shall make payment 1st.
   2. If a member is covered by another a plan or policy which has a coordination of benefits; ~~benefits, then:~~
      a. ~~If a member is covered by another prepaid health plan,~~ The ~~the~~ plan which provided or authorized the service shall make payment 1st.
      b. A plan that is not a prepaid plan that ~~If the other plan is not a prepaid plan, which~~ covers a person as an employee shall make payment ~~will pay~~ before a plan that ~~which~~ covers the a person as a dependent.
   3. If coverage is provided to ~~Relative to paying a claim for~~ a dependent child and ~~where~~ both parents have family coverage:
      a. The plan of the employee whose birthday occurs 1st in the calendar year shall ~~will~~ be primary, and the plan of the employee whose birthday occurs last in the calendar year shall ~~will~~ be secondary.
      b. If both employees have the same birthday, the plan of the employee, that has been in force longer shall ~~will~~ pay 1st.
      c. If one of the plans determines the order of benefits based upon the gender of an employee, and the plans do not agree on the order of benefits, the plan with the gender rule shall determine the order of benefits. ~~when paying a dependent child's claim~~
   4. If coverage is provided to a dependent child ~~In the event a child is covered as a dependent~~ of divorced employees, the order of benefit shall be: ~~determination relative to paying a claim for the dependent child is~~
      a. The plan of the employee with custody of the child shall ~~will~~ pay 1st;
      b. The plan of the spouse of the employee with custody of the child shall ~~will~~ pay 2nd, and
      c. The plan of the employee not having custody of the child shall ~~will~~ pay last.

C. HCG Plans shall not be primary payers for claims involving workers compensation, automobile insurance, or homeowner's insurance.

D. HCG Plans shall not have lien or subrogation rights beyond those held by health care services organizations licensed pursuant to A.R.S. § Title 20, Chapter 4, Article 9.